IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

July 21, 2006

Greg Bolen, Administrator
Life Care Center of Sandpoint
1125 North Division Street
Sandpoint, ID 83864

Provider #: 135127

Dear Mr. Bolen:

On **June 22, 2006**, a Complaint Investigation was conducted at Life Care Center of Sandpoint. Marcia Key, R.N. and Lisa Kaiser, R.N. conducted the complaint investigation. 44 survey hours were required to complete this and two other investigations at the facility. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00001340**

ALLEGATION #1:

The complainant stated residents are not receiving baths due to insufficient staff. Staff are documenting they are giving baths when they are not.

FINDINGS:

The surveyors could not validate that staff were documenting they were giving residents their baths. However, the facility was cited at F166 for failure to resolve resident grievances in regards to receiving their scheduled baths and at F312 for not ensuring all residents received their scheduled baths.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated an identified resident had a pressure ulcer on her foot. The complainant alleged the facility was documenting the pressure ulcer as an abrasion. The facility was treating the wound with a "no sting" barrier which is not an appropriate treatment for the wound.

FINDINGS:

The identified resident's record was reviewed. The wound on the resident's foot was documented as a shallow Stage 2 injury. The "no sting" barrier was used on the resident prior to applying the hydrocolloid dressing. After the wound closed, the facility continued to apply the "no sting" barrier as a skin protectant. "No sting" barrier can be used over denuded or partial thickness skin loss to assist in protecting the surrounding skin and to assist with wound dressing adherence. The properties of the barrier film provide a non-painful protective layer over the area.

The facility was cited at F314, however, for failure to prevent a Stage 2 pressure ulcer on the resident's toe.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated identified residents had sustained falls due to insufficient staffing. One identified resident had two or three falls in one day.

FINDINGS:

The identified residents' Incident and Accident investigation reports were reviewed.

The facility was cited at F225 for failure to thoroughly investigate incident/accidents; at F324 for failure at provide adequate supervision and assistive devices to prevent accidents; at F353 for failure to have sufficient nursing staff to provide nursing and related services to maintain residents at their highest level of functioning; and at F490 for failure to administer the facility in a manner that enables it to use its resources effectively and efficiently toward the betterment of each resident.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the

Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Marcia Key

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
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July 21, 2006

Greg Bolen, Administrator
Life Care Center of Sandpoint
1125 North Division Street
Sandpoint, ID 83864

Provider #: 135127

Dear Mr. Bolen:

On **June 22, 2006**, a Complaint Investigation was conducted at Life Care Center of Sandpoint. Marcia Key, R.N. and Lisa Kaiser, R.N. conducted the complaint investigation. A total of 44 hours were required to complete this and two other investigations at this facility. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00001487**

ALLEGATION #1:

The complainant stated an identified resident did not get a bath from May 3 through May 23, 2006.

FINDINGS:

The identified resident's bath record was reviewed for the month of May 2006. The only documented shower was on May 2, 2006. There was no other documentation in the resident's record to indicate she had been bathed or showered any time between May 2, 2006 and May 23, 2006 when she was transported to the emergency room for a Polymicrobial toe infection.

The facility was cited at F312 for failure to provide residents with adequate bathing.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated an identified resident had a wound on her toe which became infected and draining. The wound required hospitalization and was initially discovered by a private caregiver visiting the resident.

FINDINGS:

The identified resident's record was reviewed. The facility was cited at F309 at the level of immediate jeopardy for failure to identify, assess and treat the resident's infected toe in a timely manner.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Marcia Key

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj

IDAHO DEPARTMENT OF
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JAMES E. RISCH – Governor
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July 21, 2006

Greg Bolen, Administrator
Life Care Center of Sandpoint
1125 North Division Street
Sandpoint, ID 83864

Provider #: 135127

Dear Mr. Bolen:

On **June 22, 2006**, a Complaint Investigation was conducted at Life Care Center of Sandpoint. Marcia Key, R.N. and Lisa Kaiser, R.N. conducted the complaint investigation. A total of 44 survey hours were required to complete this and two other investigations at this facility. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00001540**

ALLEGATION #1:

The complainant stated residents do not receive baths according to their care planned needs. Some residents only receive one or two showers per month. The lack of scheduled showers was especially prevalent in April and May, 2006.

FINDINGS:

Review of bathing records and resident grievances and staff and resident interviews revealed that residents did not receive their baths according to scheduled care planned needs. The facility was cited at F166 for failure to address and resolve resident grievances in regards to residents not receiving their scheduled baths and F312 for failure to ensure residents received the necessary services to maintain personal hygiene in regards to bathing.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated there is insufficient staffing in the facility to provide for residents' needs.

FINDINGS:

Interviews with residents and staff, review of resident records and review of the facility's incident/accident reports revealed the facility did not have sufficient staff to meet resident needs. The facility was cited at F324 for failure to provide adequate supervision for residents to prevent accidents; at F353 for failure to have sufficient nursing staff to provide nursing and related services to maintain residents at their highest level of functioning; and at F490 for failure to administer the facility in a manner that enables it to use its resources effectively and efficiently towards the betterment of each resident.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Marcia Key

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
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3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

**CERTIFIED MAIL: 7000 1670 0011 3314 8897**

July 7, 2006

Greg A. Bolen, Administrator
Life Care Center of Sandpoint
1125 North Division Street
Sandpoint, ID 83864

Provider #: 135127

Dear Mr. Bolen:

On **June 22, 2006**, a Complaint Investigation survey was conducted at Life Care Center of Sandpoint by the Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be isolated and to constitute immediate jeopardy to resident health and safety. You were informed of the immediate jeopardy situation in writing on **June 21, 2006**.

On **June 22, 2006**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the resident had been removed. However, the deficiencies as identified on the revised CMS Form 2567L remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the CMS Form 2567L, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in**

**compliance.** After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 20, 2006**. Failure to submit an acceptable PoC by **July 20, 2006**, may result in the imposition of additional civil monetary penalties by **August 9, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Based on the immediate jeopardy **F309 -- S/S: J -- 483.25 -- Quality Of Care** cited during this survey, we are recommending to the CMS Regional Office that the following remedies be imposed:

> **Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]**
>
> A 'per instance' civil money penalty of **$5000.00**.
> (*THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED AT §7510*) (§488.430)

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 22, 2006**, if substantial compliance is not achieved by that time.

Your facility's noncompliance with the following:

**F309 -- S/S: J -- 483.25 -- Quality Of Care**

has been determined to constitute substandard quality of care as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) require that the attending physician of each resident who was found to have received substandard quality of care as well as the State board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

> The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:
>
> Resident #1 as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **July 20, 2006**. If your request for informal dispute resolution is received after **July 20, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

**STATE ACTIONS** effective with the date of this letter (**July 7, 2006**):

Due to the serious nature of the deficiencies at **C784**, the Department is placing the facility on a

**Provisional License**. Enclosed is Skilled Nursing Facility License #**80**. This license is effective through **January 7, 2007**. The conditions of the Provisional License are as follows:

1. Correction of all the deficiencies, with special attention to correction of C784.

2. The facility must obtain weekly consultation from a qualified RN, licensed in Idaho, who is not an employee of the facility. A corporate RN consultant can meet this requirement. The consultant must provide weekly reports to this office, indicating each deficient area has been reviewed, and corrective actions taken, and the current status of each deficient area.

3. A ban on all admission is being placed on the facility, effective the date of this letter, in accordance with *Title 3, Chapter 12, Rules Governing Long Term Provider Remedies in Idaho*, Section 16.03.12.004.08, which allows additional remedies when non-compliance with program requirements is found.

   IDAPA Section 16.03.12.004.08., states:

   > 08. Ban on Admissions. Such bans to the facility or to any part thereof shall remain in effect until the State Survey Agency determines that the facility has achieved substantial compliance with all program requirements or until a substitute remedy is imposed.

**Failure to comply with the conditions of the Provisional License may result in revocation of the facility's license.** *IDAPA 16.03.02.003.05.a.* states:

a. Additional causes for denial of a license may include the following:

   I. The applicant has violated any conditions of a Provisional License.

Please be advised that you are entitled to request an administrative review regarding the issuance of the Provisional License. In order to be entitled to an administrative review, you must submit a written request to the State Survey Agency within fourteen (14) days from the date upon which you received this letter. The request must state the grounds for the facility's contention that Provisional License was inappropriate. Because a Provisional License may be issued whenever a facility is in substantial compliance with but does not meet every requirement or rule, during the review, you would be expected to demonstrate that none of the findings of deficiency were justified.

In any administrative review, you should be prepared to demonstrate that the Department's findings were in error.

You should also include any documentation or additional evidence that you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to, Randy May, Deputy Administrator, Division of Medicaid, 3232 Elder Street, PO Box 83720, Boise ID 83720-0036, Phone #: (208) 334-5747, Fax #: (208) 364-1811.

The rules and regulations governing the conduct of an administrative review are set forth at *IDAPA 16.05.03.300*. If you fail to timely request an administrative review, the Department's decision to impose remedies as set forth herein becomes final. Please note that issues, which are not raised at an administrative review, may not later be raised at higher level hearings (*IDAPA 16.05.03.301*).

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135127 | A. BUILDING _____ B. WING _____ | C 06/22/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF SANDPOINT | 1125 N DIVISION ST SANDPOINT, ID 83864 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br>The following deficiencies were cited during a complaint investigation at the facility.<br><br>The surveyors conducting the investigation survey were:<br><br>Marcia Key, RN, Team Coordinator<br>Lisa Kaiser, RN<br><br>Survey Definitions:<br><br>MDS = Minimum Data Set assessment<br>RAI = Resident Assessment Instrument<br>RAP = Resident Assessment Protocol<br>DON = Director of Nursing<br>LN = Licensed Nurse<br>RN = Registered Nurse<br>CNA = Certified Nurse Aide<br>ADL = Activities of Daily Living<br>MAR = Medication Administration Record | F 000 | *This plan of correction is submitted as required under Federal and State statues applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.*<br><br>RECEIVED<br>JUL 19 2006<br>FACILITY STANDARDS<br><br>F-166 | |
| F 166 SS=E | 483.10(f)(2) GRIEVANCES<br><br>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, record review, and complaints from the public, it was determined the facility failed to resolve resident grievances in a timely manner. Grievances were reviewed for the months of April, May and June 2006. Six grievances were signed by the facility's Executive Director as completed when little or no | F 166 | SPECIFIC RESIDENTS<br><br>Resident # 2 has been spoken to about concerns and has verbalized satisfaction with facility corrective action and has voiced no further concerns.<br><br>Resident # 4's concern with staff has been addressed and no further concerns have been voice. Staff involved was educated and no | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| S. Bolan | ED | 07-17-06 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 135127 | A. BUILDING _____ B. WING _____ | C 06/22/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LIFE CARE CENTER OF SANDPOINT | 1125 N DIVISION ST SANDPOINT, ID 83864 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 166 | Continued From page 1<br><br>documentation was provided in the "Facility Investigation & Response" portion of the grievance form. This deficient practice affected 6 random residents (#s 2, 3, 4, 5, 6, 7). Findings include:<br><br>1. Resident # 7's grievance report, dated 5/11/06 at 11:50 am, documented the following information:<br><br>*Concern or Comment - "[Complainant's name] complained of CNA [CNA's name] being rude & very late getting [resident #7] to breakfast which ended up being very cold. [Complainant's name] feels [CNA] does not know how to 'handle' [resident #7] which has caused him to have several hard days. [Complainant's name] wishes to speak to someone."<br><br>*Facility Investigation & Response - blank<br><br>*Action Taken to Resolve/Respond to Concern - blank<br><br>The grievance form was signed by the facility's Executive Director (ED) and dated 5/30/06.<br><br>2. Resident #4's grievance report, dated 5/26/06 at 12:00 pm, documented the following information:<br><br>*Concern or Comment - "1 staff (identified as [staff member's name]) touches food, Licks fingers & Licks Lids of bowls when serving. Broadspread: Staff touching food during meal set up. [Broadspread]: Staff not washing hands between resident care. | F 166 | additional concerns have been identified regarding this staff member.<br><br>Resident # 5's slippers were discarded due to their poor condition and a hazard to the resident. Family is aware they were discarded and satisfied with the follow-up of the concern.<br><br>Resident # 6's concern with staff has been addressed and no further concerns have been voiced. The staff member was educated and the resident has verbalized comfort with this staff to continue to care for him.<br><br>Resident # 7's concern with staff has been resolved, as this staff member is no longer employed. No other concerns have been voiced.<br><br>Resident # 3 has discharge.<br><br>OTHER RESIDENTS<br><br>This practice has the potential to affect all residents. Resident concerns and grievances are acted upon promptly. This includes complaints related to staff behavior, and missing items. Resolution of the grievances are documented on the concern complaint | |



S. Bolan SD 07-17-06

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| LIFE CARE CENTER OF SANDPOINT | 1125 N DIVISION ST SANDPOINT, ID 83864 |

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|---|---|---|---|---|
| F 166 | Continued From page 2<br>*Facility Investigation & Response - blank<br><br>*Action Taken to Resolve/Respond to Concern - blank<br><br>The grievance form was signed by the facility's ED and dated 5/30/06.<br><br>3. Resident #5 grievance report, dated 5/28/06 at 11:20 am, documented the following information:<br><br>*Concern or Comment - Lost - missing pair hand chrocheted [sic] slippers mauve & white.<br><br>*Facility Investigation & Response - blank<br><br>*Action Taken to Resolve/Respond to Concern - blank.<br><br>The grievance form was signed by the facility's ED and dated 5/30/06.<br><br>4. Resident #6's grievance report, dated 5/19/06 at 1:30 pm documented the following information:<br><br>*Concern or Comment - "[Resident #6] had a headache & was seeking Tylenol from [name of LN]. She ignored his needs & [resident #6] stated 'I didn't know you had such a dark side' To which she replied 'Your true colors are showing' Resident stated her attitude was poor & she gave him lip."<br><br>*Facility Investigation & Response - blank<br><br>*Action Taken to Resolve/Respond to Concern - blank | F 166 | form before the Executive Director (ED) signs off on them.<br><br>Grievances related to staff behavior are investigated as abuse/neglect and reported to the State as required.<br><br>SYSTEMIC CHANGES<br><br>Grievances related to staff behavior are investigated as abuse/neglect and reported to the State as required.<br><br>Staff was in-serviced on appropriate responses to residents concerns and on prevention of abuse/neglect on 7-18 and 7-19.<br><br>The Life Care Centers of America concern comment program has been implemented. Staff was in-serviced on the program on 7-18 and 7-19.<br><br>The ED reviews all grievances for completion prior to signing.<br><br>A grievances tracking log has been implemented to ensure completion and timely resolution of grievances.<br><br>Grievances will be brought to the monthly Performance Improvement | |



S. Bolen RD 07-17-06

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 135127 | A. BUILDING _____ B. WING _____ | C 06/22/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF SANDPOINT | 1125 N DIVISION ST SANDPOINT, ID 83864 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 166 | Continued From page 3<br><br>The grievance form was signed by the facility's ED and dated 5/29/06.<br><br>5. Resident #2's grievance report, dated 5/24/06 at 1:15 pm, documented the following:<br><br>*Concern or Comment - " Wife & Daughter asked for S.S. [Social Services] went down to RM [room] & Both of them stated some concerns they have incountered [sic] since admit. 1) Bowel concern R/T [related to] medication given 2) pain medication & when & why & dose 3) What PRN [as needed] ment [sic] & when that was given 4) Transfer [with] tube and how staff is to do that 5) wanted to Transfer to VA [Veterans' Administration] hosp. [hospital] 6) How come Family needs to provide oral care. 7) Cath. [catheter] D/C [discontinued] and poss. [possible] s/s [signs and symptoms] of UTI [urinary tract infection] for 4 Days before they felt staff responded now has full blown UTI."<br><br>*Facility Investigation & Response - "Individual designated to investigate concern: [name of corporate nurse consultant]" No other information was documented in this portion of the form.<br><br>*Action Taken to Resolve/Respond to Concern - "Depression Scale completed 5/25/06 - fax to MD for request of antidepressant & consul[tation] [with] psychiatrist. Ativan now prn. RD [Registered Dietician] consult done 5/24/06. O2 [oxygen] sats [saturation] now to be done Q [every] shift & written on MAR." Documentation in this portion of the form identified that the information had been reviewed with the resident's wife on 5/25/06 and that the "Concerned party's response to action plan/outcome" was "pleased." | F 166 | (PI) meeting so that identified trends can be addressed.<br><br>MONITORS<br><br>Social Service Director (SSD) will monitor through the grievance tracking log.<br><br>ED will monitor through review and signing of each grievance.<br><br>DATE OF COMPLIANCE: 7-25-06 | |



S. Bolen RD 07-17-06

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| F 166 | Continued From page 4<br><br>The grievance form was signed by the facility's ED and dated 5/26/06.<br><br>There was no documentation on the grievance form regarding the facility's investigation regarding oral care, the bowel concern, the resident's wish to transfer to the VA, or the issue with the catheter and the subsequent urinary tract infection.<br><br>6. Resident #3's grievance report, dated 4/18/06 at 12:15 pm, documented the following information:<br><br>*Concern or Comment - "After lunch tray was brought to room, P.T. [physical therapy]/[name of PT] entered room. Resident states she described her condition and therapy given by [name of 2nd PT] (of [name of business]). States [name of physician] had told resident there are only 3 therapists in town he'd trust...with her particular back problem: [name of second PT], [last name of 3rd PT], and one other. [Name of 2nd PT] provided therapy and following/because of the therapy session was admitted to [local area hospital] and on Morphine x4 days. Resident states [name of physician] advised resident to stop therapy and consult [with] therapist/[name of 2nd PT], which she did. States [name of 2nd PT] told [resident #3] on 9/18/06 she's too fragile and with poor stability in her lower back, resident should not have therapy until surgery is done, that after surgery some therapy could be done but not before. States that [name of physician] said, when resident was released from her 4-day stay in which she received Morphine, that she should be sedentary and spend a lot of time on her back, | F 166 | | |



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| F 166 | Continued From page 5<br><br>that discharge orders were for bedrest, chair sitting, and bedside commode prior to the decision to admit to [name of facility].<br><br>Resident asked P.T. to call [name of 2nd PT] and consult with her and resident was told 'I'm not going to do that. I wouldn't talk to a woman. I have a Master's Degree and I've worked with geriatrics for six years.'"<br><br>*Facility Investigation & Response - blank<br><br>*Action Taken to Resolve/Respond to Concern - blank<br><br>The grievance report was signed by the facility's ED and dated 4/19/06.<br><br>On the morning of 6/21/06, the facility's ED was interviewed regarding the resolution of grievances. The ED acknowledged that he had no doubts that the above-mentioned grievances were resolved. He was not able to produce documentation of the resolutions. In regards to resident #7's grievance alleging a CNA was rude, he stated, "She doesn't work here anymore..." In reference to resident #2's allegation of staff touching food during meal set-up and that they didn't wash their hands in between cares, he stated, "...I made an observation in the dining room and did not see this [staff touching food, licking their fingers] occurring..." In regards to resident #3's grievance about an encounter with a specific PT, he stated, "we checked into that...that was a personality conflict..."<br><br>The facility failed to ensure that resident grievances were resolved. The facility's Executive | F 166 | | |



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| F 166 | Continued From page 6<br>Director signed each grievance as completed with little or no documentation present to indicate specifics of the facility's investigation and the outcome of the grievance. | F 166 | | |



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| F 225 SS=E | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is not met as evidenced | F 225 | F-225<br><br>SPECIFIC RESIDENTS<br><br>Resident # 15 and # 9 have discharged.<br><br>Resident #'s 1, 7, 8, 10, 11, 12, 13, 14, 16, 17, 18 and 19 will have all injuries of unknown origin thoroughly investigated to determine cause and preventive measures implemented as necessary.<br><br>OTHER RESIDENTS<br><br>This practice has the potential to affect all residents. Residents who sustain a fall or have injuries of unknown origin have a thorough investigation of the event to determine cause, rule out abuse/neglect and preventive measures implemented as appropriate.<br><br>SYSTEMIC CHANGES<br><br>A new revised accident/incident form has been implemented to ensure a more complete investigation. | |



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| F 225 | Continued From page 8<br>by:<br>Based on review of the facility's Incident/Accident (I/A) reports, staff interview, and three complaints from the public, it was determined the facility did not ensure that unwitnessed falls/ and or injuries of unknown origin were thoroughly investigated to rule out abuse or neglect. One I/A report of the 3 months of I/A reports reviewed, (Resident #15's) documented she had an unwitnessed fall resulting in harm when she sustained a hip fracture. There was no documented evidence the facility ruled out staff error, abuse or neglect. (Resident #1) sustained an injury of unknown origin to her right great toe. There was no immediate investigation as to the probable cause of the injury. She was harmed when she developed a Polymicrobial infection in the toe requiring hospitalization and treatment with oral, topical, and intravenous antibiotics. Also, the I/A reports for residents (#1 and #s 7 through 19) recorded no Executive Director or designee signatures to verify the reports were reviewed to determine if the investigations were completed. This person must sign and date the reports, verifying completion of the investigation, within 5 working days after an I/A occurs. Findings include:<br><br>1) Resident #15's I/A report documented the following:<br><br>5/13/06 at 8:30 pm,.."Describe exactly what happened: Resident walked to restroom by herself. Body part affected: R[ight] hip...Was incident witnessed? No...Type of incident: Found on floor - fall...Resident's mental condition before incident: Alert...Activity at the time of the incident: In bathroom - ambulating/transfer...What was the | F 225 | ED and Director of Nursing (DON) have been in-serviced on accident/incident management and follow-up on 7-3-06.<br><br>Staff was in-serviced on completion of the new accident form and on fall and injury prevention on7-18 and 7-19.<br><br>Accident/incidents are brought to the Daily Stand-Up meeting for review and completion by the IDT.<br><br>ED & DON review and sign each accident/incident form following completion of the form and within 5 days of the event.<br><br>MONITORS<br>ED and DON will monitor through review and signing of the accident/incident reports.<br><br>DATE OF COMPLIANCE: 7-25-06 | |



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| F 225 | Continued From page 9 | F 225 | | |

resident's mental condition after the incident? Alert & oriented...Describe the resident's intensity of pain after the incident: 7-10 [on pain scale]...Was first aid administered? R leg shorter than left R leg turned outward - [increased] pain...Was person involved taken to a hospital? Yes...Was another resident or associate involved? No..."

The section, FOUND ON THE FLOOR/FALL, documented the following:

"...Describe the circumstances: CNA answering call light found resident on floor...Approximately how long was the resident on the floor before he/she was found? 30-60 sec[onds]. Resident's mobility status? Ambulates independently. What, if any, environmental barriers potentially contributed to the incident? Not sure hand rails on sides of commode?..What fall reduction measures were in place? Hand rails sides of commode - non skid strips...Was another resident involved? No...Was an associate involved? No...When was the resident last seen by staff, and by whom? [This was left blank]..."

The section of the form titled, WITNESS INTERVIEW FORM, documented the following: "...Title of witness: NA [ nurse assistant]...While charting I saw her bathroom light go off so I went into her room & found her on the bathroom floor with her right leg bent to the left and under her left leg I lifted her left leg and the right leg rotated outward and she screamed when it moved so I told her that I'm going to get [name of staff] and I be back and I went & got [name of staff.]"

On 6/21/06 in the afternoon, the DON was asked



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| F 225 | Continued From page 10<br><br>if further investigative documentation was available regarding this incident. She provided a report titled, Incident Follow-Up & Recommendation Form, dated 5/16/06, which documented the following:<br><br>"I have reviewed all investigative data and have made the following determination: (check one): [First box] No abuse, neglect, misappropriation, [second box] Unable to substantiate abuse, neglect or misappropriation, [third box] Abuse, neglect of misappropriation substantiated." None of the boxes were checked. The signature lines for Executive Director, Director of Nursing and Medical Director, along with dates, were blank.<br><br>The section SUMMARY OF INVESTIGATIVE FACTS, and an attached Interdisciplinary Progress note, re-stated the same findings as previously documented one the I/A form. The section, ACTIONS TAKEN, documented, "All intervention in place - res[ident] terminal diagnosis - [no] surgery - monitor pain/healing res has been independent - remind call for help." FOLLOW-UP [None]." Also attached to the Incident Follow-Up & Recommendation Form were copies of a Fall Risk Assessment form, dated 5/16/06 and an Initial 24 Hour Careplan, dated 5/16/06.<br><br>The NA, who was the first documented person to see the resident after the incident, identified he moved the resident in a manner which caused her affected leg to rotate outward resulting in the resident screaming out in pain. There was no documented evidence that the facility interviewed the staff member to determine that the resident should not have been moved until licensed staff | F 225 | | |



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| F 225 | Continued From page 11<br>assessed the resident for injuries. The resident was harmed when she sustained a right hip fracture.<br><br>The Executive Director was interviewed on 6/21/06 at approximately 6:30 pm regarding his role during the investigation process. He stated the A & I Committee consisted of the DON, Nurse Manager, and staff from Social Services and Activities. He stated the committee reviews incidents and accidents on a routine basis.<br><br>The facility failed to thoroughly investigate this I/A when they did not interview the alert resident to determine the cause of the fall, which resulted in a hip fracture, to rule out the possibility of staff error, a second resident involvement, or abuse/neglect. The facility also did not interview other staff who worked that shift to rule out the same issues.<br><br>Based on the available documentation, this was an I/A which was of unknown origin, was not ruled out as being staff error, abuse or neglect.<br><br>2) Resident #1 had an occurrence on 5/23/06. The I/A report documented: "Describe exactly what happened: When removing socks, toe nail was pulled off R[ight] great toe nail revealing large open area [with] yellow slough covering wound & necrotic tissue at tip of toe. Also a 0.5 cm [centimeter] lesion to medial 2nd toe [with] yellow bed...Resident's mental condition before incident: Alert/confused..." Under the section, SKIN RELATED INJURY, the following was recorded: "Categorize the skin related injury. Infected lesion. How did it happen? Res[ident] has hx [history] of stubbing toes on furniture during | F 225 | | |



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| F 225 | Continued From page 12 | F 225 | | |

transfers...Did the injury involve equipment? Unknown, possibly stubbed on bed or w/c during transfer..." The following questions on the form were left blank: "Was there an investigation? What did the investigation reveal?"

On 6/21/06 in the afternoon, the DON was asked if the Incident Follow-Up & Recommendation Form had been completed. She indicated she had given the surveyors all the forms that she had completed. There was no follow-up information for this resident.

The facility failed to thoroughly investigate this incident to determine the probable cause of the injury. The injured toe was first observed by a private caregiver who brought the wound to the attention of the staff. There was no evidence the facility investigated why the toe had progressed to an infected wound and why the staff had to be told by the private caregiver before the facility became aware of the seriousness of the wound. She was harmed when she developed a Polymicrobial infection in the toe requiring hospitalization and treatment with oral, topical, and intravenous antibiotics.

The Executive Director or his designee did not sign the report to verify it was reviewed to determine if the investigation was complete. This person must sign and date the reports, verifying completion of the investigation, within 5 working days after an I/A occurs.

3) Resident #9 had an occurrence on 4/15/06. The I/A report documented the following: "Location of incident: Resident's room...Describe exactly what happened. Alerted by another



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| F 225 | Continued From page 13 | F 225 | | |

resident [resident #9's name] was in need of help. Found on floor on L[eft] side in front of wheel chair. Falls alarm not attached. Body part affected: none noted...Under the Section, FOUND ON THE FLOOR/FALL: Was falls alarm on? Yes. Was falls alarm sounding? Yes. Describe the circumstances: Resident leaned forward. Was the resident incontinent? No. Was the floor wet? No..."

The remainder of this section, which included the following questions, was blank: "What, if any, environmental barriers potentially contributed to the incident? Was the call light on? Was another resident involved? Was an associate involved? When was the resident last seen by staff, and by whom?

The Incident Follow-Up & Recommendation Form, dated 4/17/06, documented the following: "I have reviewed all investigative data and have made the following determination: (check one): [First box] No abuse, neglect, misappropriation, [second box] Unable to substantiate abuse, neglect or misappropriation, [third box] Abuse, neglect of misappropriation substantiated." None of the boxes were checked. The section, SUMMARY OF INVESTIGATIVE FACTS, documented: On 4/15/06 alerted by another resident @ [at] aprox [approximately] 1015 [10:15 am,] resident needed help found resident sitting in front of w/c [wheel chair] Falls alarm [not]attached to resident's clothes, slipped out [no] apparent injury..."

The facility did not thoroughly investigate this occurrence to rule out the possibility of staff error, a second resident's involvement in the incident, or



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| F 225 | Continued From page 14<br><br>abuse/neglect. The facility did not thoroughly investigate to clarify the conflicting information relating to alarms. There were no interviews by staff on duty nor statements by the resident or the second resident who reported the incident. The Executive Director, DON, and Medical Director signed and dated the investigation report as being complete.<br><br>A second I/A report, dated, 5/28/06, involving resident #9, documented that while a staff member was bathing the resident in the shower room bruises were noted on the resident's legs. An LN documented the bruise on the resident's left thigh measured 10.0 x 5.0 centimeters, the bruise on the right lateral lower leg measured 2x3 centimeters. The circumstance surrounding the bruises was unknown. There were no staff/resident interviews conducted. The follow-up report form, dated 5/30/06, concluded, "...Resident claims they were from self transferring to & from toilet to w/c & back.." This form was not signed/dated by the Executive Director.<br><br>There were similar findings for residents #7,8 and 10 through 19, who either had unwitnessed falls, or bruising/abrasions of unknown origin, which were not thoroughly investigated by the staff. The Executive Director or his designee did not sign the reports to verify they were reviewed to determine if the investigations were complete. | F 225 | | |



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| F 309 SS=J | 483.25 QUALITY OF CARE<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, record review, and a complaint from the public it was determined the facility failed to adequately assess, treat and monitor a resident's injury causing harm when she developed a polymicrobial infection in the toe requiring hospitalization and treatment with oral, topical, and intravenous antibiotics. This deficient practice resulted in serious harm, constituting immediate jeopardy to 1 of 1 sample residents (#1).<br><br>a. Resident #1 scraped her right great toe on 3/29/06 while in the facility, causing the toe to bleed at the toenail. The facility could not provide any documentation indicating the toe was assessed after the initial incident nor that it was treated or monitored. On 5/23/06, a private caregiver removed the resident's socks and observed a wound to the right great toe. The wound was visualized after the resident's toenail was pulled off due to the removal of the sock. Documentation on the incident report, dated 5/23/06, described the wound as a "...large open area..." with "yellow slough covering wound [and] necrotic tissue @ [at] tip of toe." The incident report also documented a 0.5 centimeter lesion to the medial second toe with a yellow wound base. | F 309 | F-309<br><br>SPECIFIC RESIDENTS<br><br>Resident #1's toe and abdomen wound is slowly healing and is free of infection at this time. Her Braden Risk Assessment and care plan has been up-dated.<br><br>OTHER RESIDENTS<br><br>This practice has the potential to affect all residents. Residents whom sustain an injury have an assessment of the injury completed each shift for 72 hours or until the condition has stabilized. Their physician and family are notified as required and treatment rendered as ordered.<br><br>SYSTEMIC CHANGES<br><br>License nurses were in-serviced on accident/incident management, skin assessments, wound documentation, identifying change of condition, and notification of physician and family requirements on 6-23, 7-18 and 7-19. | |



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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 309 | Continued From page 16<br><br>The resident was sent to a local emergency room and admitted to the hospital for evaluation and treatment. It was determined she required intravenous antibiotics for a diagnosed infection.<br><br>This failed practice was brought to the attention of the facility's Administrator, DON, Corporate Nurse Consultant and the Director of Medicare Services on 6/21/06 at 6:15 pm. The facility was provided with specific details of this deficient practice that resulted in a serious wound to resident #1.<br><br>On 6/22/06 at 12:40 pm the facility presented the surveyors with an acceptable plan of correction and the immediate jeopardy was abated.<br><br>The plan of correction was as follows:<br><br>"1. Resident #1's wound has been assessed and documented. Braden Skin Risk Assessment has been updated. Care Plan has been reviewed and updated to reflect residents current medical status.<br><br>2. All residents feet were assessed for skin breakdown on 5/23/06 and 5/24/06. No new skin breakdown was identified. Head to toe skin checks completed on residents on 6/21/06 and 6/22/06 and documented on weekly skin check sheets.<br><br>3. L.N.'s will be inserviced on LCCA's [Life Care Corporation of America's] Prevention of Pressure Sores and Other Ulcers Policy by 6/23/06.<br><br>CNA's will be inserviced on procedure for reporting skin issues on 6/23/06. | F 309 | Nursing Assistants were in-serviced on identifying and reporting changes in skin condition on 6-23, 7-18 and 7-19.<br><br>Audits are performed weekly to ensure skin assessments are completed as scheduled.<br><br>Newly identified skin conditions are brought to the daily stand-up meeting to ensure appropriate actions have been taken.<br><br>Skin and fall prevention in-services are scheduled quarterly.<br><br>MONITORS<br><br>ED and DON will monitor through attendance of the daily stand-up meetings and the monthly PI meetings.<br><br>DON and Resident Care Managers (RCM) will monitor through the weekly skin assessment audits.<br><br>DATE OF COMPLIANCE: 7-25-06 | |



S. Boles SD 07-17-06

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| F 309 | Continued From page 17<br><br>Braden Risk Assessments will be updated for all residents. Residents scoring 14 or below will have Pressure Ulcer Prevention Checklist completed. Residents identified at moderate or high risk for skin breakdown, will have Care Plan's reviewed and updated. To be completed by 6/30/06.<br><br>LN's will be inserviced on LCCA skin documentation forms for Pressure Ulcers, Stasis Ulcers, and non-pressure related skin on 6/23/06.<br><br>All skin issues identified will be recorded on approp. [appropriate] skin form, assessed weekly with documentation until resolved per LCCA policy by 6/23/06 and ongoing.<br><br>Weekly head to toe skin integrity assessments will be performed and documented on each resident's individual Weekly Skin Integrity Assessment form by 6/22/06 and ongoing.<br><br>Residents identified with Dx. [diagnosis] of Diabetes will have weekly Diabetic Foot Checks completed by L.N. and documented on individual treatment sheets. Care Plans will be updated to reflect new intervention by 7/1/06 and on-going.<br><br>L.N. inservice on 6/23/06 to include policy & procedure for initiation and completion of Weekly Diabetic Foot Checks.<br><br>Ongoing LN inservices will be provided on Wound Assessment and Documentation, Complications of Diabetes and Prevention of Pressure Sores and Other Ulcers on New Hire Orientation, and quartly [sic] for all LN staff.<br><br>SDC [Staff Development Coordinator] will | F 309 | | |



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| F 309 | Continued From page 18<br><br>complete L.N. Competencies on Pressure Ulcer Assessment and Pressure Sore Management Treatment Modalities for each L.N. By 7/30/06. Newly hired L.N.'s will complete competencies during probationary period.<br><br>4. RCM [Resident Care Manager] will audit treatment sheets for completion of Weekly Diabetic Foot Checks, Weekly Skin Integrity Assessment forms, individual skin assessment sheets for completion daily, with copy of audit to D.O.N. by 7/1/06 and ongoing.<br><br>D.O.N. to do random audit of Weekly Skin Integrity Assessment forms, Individual Skin assessment sheets, and treatment sheets for Diabetic Foot Checks by 7/1/06 and ongoing.<br><br>RCM will complete LCCA Weekly Pressure Ulcer Tracking form and the Weekly Non-Pressure Tracking form and forward copy to D.O.N. by 7/1/06 and ongoing.<br><br>D.O.N. will do random chart audits for residents identified with newly acquired Pressure Ulcers to ensure approp. notification, treatment plan and documentation is in compliance.<br><br>D.O.N. will do random chart audit for new admissions to ensure assessments, documentation and treatments are approp.<br><br>Audits completed and reviewed by D.O.N. will be evaluated monthly for performance improvement opportunities by the CQI [Continuous Quality Improvement] committee.<br><br>The E.D. [Executive Director] will monitor and | F 309 | | |



S Bolen ED 07-17-06

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| F 309 | Continued From page 19<br>ensure compliance."<br><br>"Amendment to P.O.C. [plan of correction] 6/22/06<br><br>The Nurse Consultant that will be in the facility/available for consultation effective 6/22/06 is [name and credentials of RN #1] (licensed in ID [Idaho]). [Name of RN #1] will be in the facility until [Name of Corporate Nurse Consultant and credentials (RN#2)] has received her ID license. [Name of Corporate Nurse Consultant] has started this process today. The Nurse Consultant will monitor and insure compliance of P.O.C.<br><br>[Name of RN #1] will remain in this capacity for a minimum of 3 wks [weeks]. At that point if [name of RN #2] has her ID license then she will become the consultant if not [RN #1] will remain until [RN #2] receives her license."<br><br>b. Resident #1 was harmed when the facility failed to adequately assess, monitor, and notify the treating physician in a timely manner when the resident's abdominal wound first presented with signs and symptoms of wound infection and deterioration.<br><br>Findings include:<br><br>Resident #1 was admitted on 3/27/06 with diagnoses including s/p (status post) exploratory laparotomy for negative appendectomy, chronic right pleural effusion, congestive heart failure, acute abdominal pain, streptococcal bacteremia, septicemia with mental status changes, diabetes mellitus, rheumatoid arthritis, atrial fibrillation, coronary artery disease, and chronic renal | F 309 | | |



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| F 309 | Continued From page 20<br>insufficiency. Upon admission to the facility, the resident had an open surgical wound to her abdomen.<br><br>a. A nursing note, dated 3/27/06, documented the resident's admission assessment and her skin assessment was as follows: "Skin intact [with] Large Callaces [sic] noted on lateral sides of each foot...Has ST [skin tear] to LFA [left forearm] that is dry & exposed area 2 x 1.5 cm [centimeters] [with] redness noted [at] edges. Old ST to RFA [right forearm] 1.5 x 0.5 cm. CT [chest tube] insertion site to [right] lower chest wall approx[imately] 0.5 cm [with] sutures intact..." The nursing note also documented the resident had a dressing over the right lower quadrant of her abdomen.<br><br>A "Weekly Skin Integrity Assessment" form documented an assessment, dated 3/27/06. In addition to the wounds identified on the admission assessment, the form documented an area of "watery blisters on [left] side" and an area of skin breakdown on the resident's buttocks.<br><br>Nursing notes, dated 3/29/06 at 8:45 pm, documented "Res[ident] stated she was trying to stand at toilet [and] scrapped [sic] her [right] great toe on the slip strip causing her toe to bleed at toenail..." Nursing notes, dated 3/30/06 at 9:30 am, documented "A & I [accident and incident] Committee reviewed injury to [right] great toe which occurred 3/29/06 [at] 2000 [8 pm]. She attempted to stand by self & scraped toe on non-skid surface. Socks to be worn & reminded resident to use call lt [light]."<br><br>There was no other documentation in the nursing | F 309 | | |



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| F 309 | Continued From page 21<br><br>notes or on the weekly skin assessment forms regarding the treatment or monitoring of the toe injury.<br><br>An incident and accident report, dated 5/23/06 at 7:30 am, documented the following regarding what occurred when a visitor removed the resident's socks because they were soiled and a foul odor was noted:<br><br>"When removing socks, toe nail was pulled off [right] great toe nail revealing large open area [with] yellow slough, covering wound & necrotic tissue [at] tip of toe. Also a 0.5 cm lesion to medial 2nd toe [with] yellow bed." The report documented the wound was cleaned, a dressing was applied, and the resident was transported to a local emergency room for evaluation.<br><br>The investigation portion of the report documented a skin related injury and categorized it as an "infected lesion." The "How did it happen?" section of the investigation form documented, "Res has hx [history] of stubbing toes on furniture during transfers."<br><br>The resident was admitted to the hospital on the same day and diagnosed with a "polymicrobial diabetic foot infection." The resident received aggressive antibiotic treatment in oral, intravenous (IV) and topical forms. The hospital discharge summary, dated 5/27/06, documented the following: "Superficial swab cultures revealed Enterococcus sensitive to vanco [Vancomycin], MRSA [Methicillin-resistant Staphylococcus aureus] sensitive to Septra and vanco and resistant to amoxicillin and sulbactam." Upon re-admission to the facility on 5/27/06, the | F 309 | | |



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| F 309 | Continued From page 22<br>resident was receiving IV antibiotic therapy.<br><br>A physician's progress note, dated 6/5/06, documented "I was asked to see [resident #1] today because her order for Vancomycin has expired. She was ordered for Vancomycin 1 gram Q [every] 48 hours for 14 days. Her right foot, for which the Vancomycin was ordered, looks much better. Her great toe is no longer reddened but it does have a lot of eschar on the tip and an absent nail. I see a potential space under the eschar that leads down toward the bone. I don't know if it goes all the way to the bone...I am going to continue the Vancomycin for another 2 weeks at 1 gram IV Q 48 hours."<br><br>On 6/21/06, the facility provided the surveyors with an investigation report regarding the incident that occurred on 5/23/06. The investigation was dated 6/21/06 and documented the following:<br><br>"On May 23, 2006, [visitor's name], Residents former personal caregiver at home was removing [resident #1's] socks when part of her right great toe nail came off during sock removal. [Visitor's name] then informed the team leader [name of LN], LPN what had just happened and also got Social Services Assistant [name] involved. [Social Services Assistant] then notified [a second LN's name], LPN of the incident who went to the Residents room, looked at the toe, covered it with a dressing and notified the Physician. She also notified [name of corporate nurse consultant] of the incident. An incident report was initiated.<br><br>On 5/23/06 & 5/24/06 All Residents in the facility had their feet checked for any unidentified skin issues. There was no new skin breakdown noted. | F 309 | | |



J. Boken SD 07-17-06

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| F 309 | Continued From page 23<br><br>MDs were notified if Podiatrist evaluations were needed. Residents that had not had a shower in the past week were identified and received a shower.<br><br>On 5/23/06, Facility investigation to rule out abuse or neglect was initiated Executive Director [name] contacted [physician's name] to find out the status of [resident #1's] great toe, he [the physician] felt at that time the infection was part of a possible Hematogenous infection that spread from her open abd [abdominal] wound, and he did not feel that this was from abuse or neglect.<br><br>On 5/24/06 [name of Executive Director] interviewed staff members who provided care to [resident #1], all staff members that were interviewed stated that they did not remember any open wounds on her right great toe & most could not remember seeing her without her socks on [,] list of staff that were interviewed [list of 10 names]...<br><br>After chart review and staff interviews abuse and neglect could not be substantiated.<br><br>Facility Management discussed plan to identify training needs of staff members and develop a training plan/ schedule when new DON started her position on 5/31/06.<br><br>On 6/21/06 Interviewed [name of occupational therapist] who was the OT [occupational therapist] providing showers and ADL training until the end of March, during that time she was showered 3 times per week by OT. She was not making any progress so OT did not continue to work with her, [resident #1] did stub her right | F 309 | | |



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| F 309 | Continued From page 24<br><br>great toe during that time and the toe was bruised and oozing, [name of OT] did notify [name of LN] at that time and that [name of same LN] was applying a dressing."<br><br>The resident's bath records were reviewed for the month of May 2006. The only documented shower was on 5/2/06. There was no other documentation in the resident's record to indicate she had been bathed or showered any time between 5/2/06 and 5/23/06 when she was transported to the emergency room for the polymicrobial toe infection.<br><br>The bath record for the month of April revealed the occupational therapist showered the resident on 4/7, 4/10, 4/11/, 4/12, 4/17, 4/19, 4/21, 4/24, and 4/28/06.<br><br>Weekly skin assessments were documented as completed for the resident on 3/27, 4/1, 4/8, 4/15, 4/29, and 5/7/06. There was no other documentation to indicate if skin assessments had been performed after 5/7/06. The weekly skin assessments contained no documentation pertaining to the resident's feet or toes.<br><br>An interview was conducted with the DON and the RN Director of Medicare Services on 6/21/06 at 4:06 pm. When asked to provide assessments following the toe injury on 3/29/06, the RN Director of Medicare Services stated, "There was no injury to follow-up on..." According to the nursing notes for 3/29/06, the toe was scraped and bleeding. In regards to staff members not noticing the wound on her toe in May, she stated, "I know that she was not allowing the girls to take her socks off for a period of time." There was no | F 309 | | |



J. Bolan RD 07-17-06

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| F 309 | Continued From page 25<br>documentation identifying the resident's refusals to remove her socks. The RN stated she was "shocked" when she saw the toe wound on 5/23/06.<br><br>The facility failed to adequately assess, treat and monitor this resident's injury causing harm when she developed a polymicrobial infection in the toe requiring hospitalization and treatment with oral, topical, and intravenous antibiotics. This resulted in serious harm to the resident, constituting immediate jeopardy. On 5/23/06, a private caregiver visiting the resident, discovered a wound on the resident's right great toe and 2nd toe which required hospitalization and aggressive antibiotic treatment. The facility had no documentation of ongoing foot assessments for this diabetic resident, there was no follow-up for a toe injury in late March, bath records revealed the resident received only one shower during the month of May prior to her hospitalization on 5/23/06 and the last documented skin assessment was on 5/7/06. There was no documentation in the nursing or occupational therapy notes to indicate the resident had a bruised and oozing right great toe except in the facility's investigation report dated 6/21/06.<br><br>b. At the time of admission on 3/27/06, resident #1 had an open abdominal wound as a result of an exploratory laparotomy incision that had to be re-opened during a recent hospitalization. The hospital discharge summary documented that when the laparotomy incision was re-opened, the wound contained clear fluid and "...did not grow any organisms on culture." The resident was discharged to the facility with orders for wound care and dressing changes. | F 309 | | |



J. Bolen RN 07-17-06

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| F 309 | Continued From page 26<br><br>Nursing notes regarding the wound documented the following:<br><br>*3/27/06 3:00 pm - "...Abd [abdomen] large, soft, Has drsg [dressing] over RLQ [right lower quadrant]..."<br><br>*3/27/06 9:25 pm - "...Res[ident] incision on [right] side 3 cm [centimeters] long [with] gauze packing. Dressing [changed] ABD [type of absorbent wound cover] applied. Lg [large] amt [amount] of clear drainage...Res started on 500 mg Keflex for infection..."<br><br>*3/28/06 5:00 am - "...Dressing was saturated [with] brownish sero sanguinous drainage and changed..."<br><br>*3/28/06 3:00 pm - "...Wound bed pink [with] adipose tissue exposed. Moderate amounts of serous drainage, [no] odor noted. Edges pink [without] s/sx [signs or symptoms of] inflammation..."<br><br>*3/29/06 8:45 pm - "...Dressing was [changed] on abdomen. Kerlex & NS [normal saline] applied to incision site & ABD pads covered..."<br><br>*3/30/06 2:30 pm - "...Con't [continue] [with] wound care. Area cleaned [with] NS, old dsg [dressing] had copious amounts of serious [sic] drainage [no] odor noted. Area covered [with] dry dsg..."<br><br>*3/30/06 10:30 pm - "...Abdominal wound - packing in place..." | F 309 | | |



S. Boka RD 07-17-06

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| F 309 | Continued From page 27<br>*3/31/06 3:15 pm - "...Incision to RLQ [right lower quadrant] con't to have large amounts of serious [sic] drainage [without] odor..."<br><br>*4/1/06 2:50 pm - "...Incision to the RLQ continues to have serous drainage. Dressing has been changed..."<br><br>*4/2/06 4:00 am - "...Abd[omen] wound tissue is gray marbled [with] yellow adipose tissue..."<br><br>*4/4/06 1:45 pm - "...Abd wound to RLQ con't to drain large amounts of serous drainage area open [with] adipose tissue exposed. [No] redness or s/sx inflammation [at] site..."<br><br>*4/6/06 3:00 pm - "...RLQ wound con't to have moderate to large amount of serous drainage. Old dsg has slight 'fishy' odor..."<br><br>*4/7/06 3:50 pm RLQ wound con't to have moderate to large amount of serous drainage. Wound lower edge dry & brown. Wound bed is all exposed adipose tissue. Wound con't to have 'fishy' odor..."<br><br>*4/8/06 2:50 pm - "...RLQ continues to have moderate amount of serous drainage. It also have [sic] a strong odor..."<br><br>*4/9/06 1:00 pm - "...Abd wound located on the RLQ requires wet to dry dressing which was done. The area around the wound feels a little hard to the touch, there was minimal odor today, minimal serous drainage also..."<br><br>*4/10/06 2:30 pm - "...Abd wound has large amount of purulent drainage [with] foul odor. | F 309 | | |



J. Bolen RD 07-17-06

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| LIFE CARE CENTER OF SANDPOINT | 1125 N DIVISION ST SANDPOINT, ID 83864 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 309 | Continued From page 28<br>Lower aspect of wound black & dry...MD faxed about wound status..."<br><br>*4/11/06 2:30 pm - "...[right] abd surgical site 12.3 cm x 3.0 cm & 7.5 cm depth. Tissue gray & yellow. Copious amt odorous drainage. Tx [treatment] wet to dry increased to 3x [times] a day. Wound edges debreaded [sic] on 4/4/06. Edges are again black & tender [with] reddened surrounding area..."<br><br>*4/11/06 9:20 pm - "...Wound was filled [with] purulent pus. Black around outer edges. Has an order [sic]..."<br><br>*4/12/06 2:10 pm - "...Wound open & draining copious amounts of yellow & purulent drainage. Very foul odor coming from wound. Wound bed has exposed adipose tissue, lower aspect of wound is black & dry..."<br><br>*4/12/06 9:00 pm - "Wound was full of purulent pus...."<br><br>*4/13/06 10:10 pm - "...Dressing changed this evening [right] abdomen - purulent drainage lying in wound - soaked up by 4 x 4's and cleansed w/normal saline. Wet to dry dressing covered w/ABD. [Increased] odor."<br><br>4/14/06 4:00 am - "Dressing [change] completed [with] wound on RLQ. Purulent, foul smelling pus cleaned from bottom of wound..."<br><br>4/14/06 4:00 pm - "Late entry for 4/13/06...Abd wound con't to have copious amounts of purulent drainage & very foul odor. Outer, most inferior aspect black & necrotic..." | F 309 | | |



J. Boca RN 07-17-06

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| F 309 | Continued From page 29<br><br>*4/14/06 4:00 pm - "...Abd wound assessment remains unchanged from 4/13/06...Wound culture returned today faxed to MD..."<br><br>*4/14/06 9:45 pm - "Resident moved to room...for isolation precautions. Dressing change this evening- [increased] drainage on dressing - more than last evening approx[imately] 30 cc [cubic centimeters] - purulent & [increased] odor..."<br><br>*4/15/06 10:10 pm - "...[name of surgeon] was faxed concerning description of wound - return fax 'No antibiotic but to increase dressing change to 3x's daily which is being done. [name of resident's physician] faxed at 2 pm yesterday afternoon of lab results...Dressing changed this evening - continues to have purulent drainage and foul odor..."<br><br>*4/16/06 7:00 am - "...Surgical site RLQ has putrid odor, copious amts [amounts] of yellow/gray drainage. Necrotic tissue at bottom of site [with] gray wound bed. Area surrounding wound is red warm & hard to the touch..."<br><br>*4/16/06 2:55 pm - " ...Changed dressing to RLQ surgical wound. Purulent yellowish drainage noted in dressing, also after removing old dressing copious amount of the same drainage surface [sic] on the wound bed. Use sterile 4x4 to clean the excess drainage x2. Strong foul odor emitted from the wound. Dressing was changed around 1130 am, [at] 2:00 pm it was leaking through again...<br><br>*4/16/06 3:30 pm - "[name of physician] called w/new order. ATB. [antibiotic] Levaquin 250 mg | F 309 | | |



S. Bolen RD 07-17-06

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| F 309 | Continued From page 30<br><br>[milligrams] qd [every day] x5 days [unable to read symbol] wound infection..."<br><br>Physician's progress notes documented the following in reference to the abdominal wound:<br><br>*4/3/06 - "...she has a fair amount discharge from the right lower quadrant wound. Today this is already been cleaned and does not look reddened or with huge amounts of exudate and she has no increased abdominal swelling..."<br><br>*4/10/06 - "...she developed some redness in her abdominal pannus...I am here today to see whether or not there is any reason to start antibiotics...The abdominal folds now look much better. They have been cleaning them aggressively. She does have a drapery of tissue but it's not looking cellulitic right now...So for now, I am not going to change any of her medications or add antibiotics..."<br><br>A physician's order, dated 4/11/06, documented, "Culture Abd wound..."<br><br>The results of the wound culture, dated 4/15/06, identified the resident's abdominal wound was infected with Proteus Mirabilis, Klebsiella Pneumonia, and Enterococcus Faecalis. The resident began oral antibiotic treatment on 4/16/06 per a physician's order.<br><br>Nursing notes from 4/16/06 through 5/2/06 document further deterioration of the wound. The surgeon examined the resident on 5/2/06 and ordered the resident to be seen by a wound specialist for placement of a wound vacuum (vac) which was done on 5/4/06. | F 309 | | |



SD 07-17-06

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| F 309 | Continued From page 31<br><br>The facility failed to adequately assess, monitor, and notify the treating physician in a timely manner when the resident's abdominal wound first presented with signs and symptoms of wound infection and deterioration. Nursing notes document a "fishy" smell from the wound on 4/6/06 and continued to document the presence of a foul odor with subsequent dressing changes. The resident's physician was not notified until 4/10/06 and a wound culture was not ordered until 4/11/06. Antibiotic treatment did not begin until 4/16/06, a full 10 days after the wound began to show evidence of infection and deterioration. This delay in treatment resulted in harm to the resident; her abdominal wound was infected with Proteus Mirabilis, Klebsiella Pneumonia, and Enterococcus Faecalis, required antibiotic treatment and eventually a wound vac. When the resident was admitted to the hospital on 5/23/06, hospitalization identified she had a "chronic non-healing abdominal wound." At the time of the complaint investigation on 6/21/06, the resident still required the use of a wound vac. | F 309 | | |
| F 312 SS=E | 483.25(a)(3) ACTIVITIES OF DAILY LIVING<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of resident | F 312 | F-312<br><br>SPECIFIC RESIDENTS<br><br>Resident #1 receives baths as scheduled.<br><br>OTHER RESIDENTS<br><br>This practice has the potential to affect all residents. Residents receive baths as scheduled. | |



S. Bolen SD 07-17-06

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| F 312 | Continued From page 32<br><br>council minutes, staff interview, and complaints from the public, it was determined the facility did not ensure residents received baths or showers in a timely manner. This affected 1 of 1 sample residents (#1) and random residents who attended resident council meetings in May and June 2006. Findings include:<br><br>1. Resident #1 was admitted on 3/27/06 with diagnoses including s/p (status post) exploratory laparotomy for negative appendectomy, chronic right pleural effusion, congestive heart failure, acute abdominal pain, streptococcal bacteremia, septicemia with mental status changes, diabetes mellitus, rheumatoid arthritis, atrial fibrillation, coronary artery disease, and chronic renal insufficiency. Upon admission to the facility, the resident had an open surgical wound to her abdomen.<br><br>The resident's bath records were reviewed for the month of May 2006. The only documented shower was on 5/2/06. There was no other documentation in the resident's record to indicate she had been bathed or showered any time between 5/2/06 and 5/23/06 when she was transported to the emergency room for a polymicrobial toe infection.<br><br>2. Resident Council meeting minutes were reviewed for the months of May and June 2006. The minutes, dated 5/15/06, revealed the following documentation, "1) C/O [complaints of] shower being done hit & miss..." According to documentation, 10 residents attended the May meeting.<br><br>The June minutes, dated 6/14/06, documented | F 312 | SYSTEMIC CHANGES<br><br>A protocol has been developed to ensure that bath aides are not routinely pulled to the floor during staff shortages.<br><br>A new bath schedule has been implemented to ensure all residents are schedule for baths at least two times weekly. Personal preferences for baths are scheduled as requested.<br><br>Staff was in-serviced on ensuring all necessary activities of daily living services are provided as scheduled on 7-18 and 7-19. This includes baths.<br><br>MONITORS<br><br>RCM's will monitor through weekly bath audits.<br><br>DON will monitor through review of the bath audits.<br><br>Staffing Coordinator will monitor through scheduling of Bath Aides.<br><br>ED will monitor through the monthly PI meetings and concern complaint program.<br><br>DATE OF COMPLIANCE: 7-25-06 | |



S. Boles ED 07-17-06

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| F 312 | Continued From page 33<br><br>the following in the "Old Business" section of the minutes, "1) C/O showers being done hit & miss still on going problem." The "New Business" section of the minutes documented, "2) C/O showers not being given on a regular basis..." According to documentation, 9 residents attended the June meeting.<br><br>An interview was conducted with a bath aide on 6/22/06 at 10:55 am. The aide stated that when she arrived at the facility at the beginning of her shift, she was often reassigned to work on a unit as a CNA for the day. She noted on the days she was reassigned, she may have been able to shower only 1 resident. She acknowledged that some residents may go 6 to 8 days without a bath and that this occurs on a regular basis. She identified one resident she had bathed that day, who had not been bathed in 12 days. She stated that when she arrived at work, she was handed a list of residents that were in "critical" need of receiving a shower. In reference to resident #1, the aide acknowledged that there was a long period in May when the resident did not receive a shower. She stated the facility was currently short-staffed and "...if someone calls in sick, we're hurting..."<br><br>On 6/22/06 at approximately 11:20 am, an interview was conducted with a CNA who had worked as a bath aide in the facility within the past 2 months. She stated that when she was the bath aide, she would often be reassigned to work the floor as a CNA. She acknowledged that there were about 8 showers to do per shift and the CNAs only have time to do 2 or 3 when there is no bath aide. | F 312 | | |



S. Bolen ED 07-17-06

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| F 312 | Continued From page 34<br>The facility failed to ensure residents received baths or showers in a timely manner. Resident #1 was not showered for at least 21 days and was transported to the hospital on 5/23/06 for a polymicrobial infection in her toe. | F 312 | | |
| F 314 SS=D | 483.25(c) PRESSURE SORES<br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview and a complaint from the public, it was determined the facility did not prevent a Stage 2 pressure ulcer from developing. This was true for 1 of 1 resident (#9) reviewed for pressure ulcers. The resident developed a pressure ulcer to the inner aspect of the 5th toe on her left foot secondary to tight fitting shoes. Findings include:<br><br>Resident #9's closed record was reviewed. She was admitted to the facility on 4/13/05 with diagnoses which included hypertension, dementia, diabetes mellitus, Type II with neuropathy and calluses and corns on her feet and mycotic nails. The Physician's Admission Order form, signed but not dated, by the treating | F 314 | F-314<br><br>SPECIFIC RESIDENTS<br><br>Resident # 9 was discharged from facility and a closed record.<br><br>OTHER RESIDENTS<br><br>This practice has the potential to affect all residents. Residents who have been assessed to be at risk for skin breakdown have preventive measures implemented and care planned. Weekly skin assessments are performed to identify skin issues so they may be addressed timely. Physician who request podiatry appointments for residents will have them scheduled as ordered and as resident and family allow. | |



S. Boles RN 07-17-06

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| F 314 | Continued From page 35<br><br>physician, documented the resident was to receive a Podiatry Consult for nail/callus care. An LN noted the physician order on 4/13/05 at 12:00 noon.<br><br>There was no documented evidence in the resident's record that the facility obtained this consult for the resident.<br><br>The Braden Scale was performed on 4/13/06 and quarterly thereafter. The resident scored as low risk for the development of pressure ulcers at each assessment.<br><br>The admission nurses' notes, dated 4/13/05 identified the resident had no open areas to her feet.<br><br>The note on 2/12/06 documented she had developed a Stage 2 wound to the medial aspect of her 5th toe on her left foot. The wound measured 0.4 x 0.25 cm (centimeters.) A hydrocolloid dressing, DuoDerm, was applied.<br><br>On 2/13/06 there was increased redness, warmth and swelling. The treating physician was notified and he examined the resident on 2/14/06 and ordered an antibiotic. The facility's wound team assessed the wound and identified the contributing factors were her diabetes and "poor fitting shoes. Resident's shoes changed." The team documented that the toe appeared less reddened, without drainage or pain. The wound team continued to monitor the wound.<br><br>On 2/24/06 the team documented, "..Healing ST [stage] 2 - almost resolved...less than 0.5 cm in diameter.." | F 314 | SYSTEMIC CHANGES<br><br>Diabetic foot check stickers are placed on the weekly skin assessment sheets of the diabetic residents to ensure that staff pay particular attention to their feet when assessing the skin.<br><br>Weekly audits are performed to ensure the weekly skin checks are done.<br><br>Staff was in-serviced on completing the weekly skin assessments on 6-23, 7-18 and 7-19.<br><br>MONITORS<br><br>RCM's will monitor through the weekly skin assessment audits.<br><br>DON will monitor through random weekly audits of skin assessments and the skin tracking logs.<br><br>ED will monitor through the monthly PI meeting.<br><br>DATE OF COMPLIANCE: 7-25-06 | |



J. Bolin ED 07-16-06

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| F 314 | Continued From page 36<br><br>The note, dated 3/2/06, documented the wound had resolved. The DuoDerm dressing was discontinued and a No Sting Barrier film was initiated to be applied to the resolved site two times daily for 14 days. The resident denied any discomfort to the area.<br><br>A follow-up wound team note on 3/9/06 identified the area on the resident's 5th toe remained resolved and the treatment plan of No Sting barrier film continued to be effective. "The tight shoes remain off. Resident denies any pain or discomfort."<br><br>The Annual MDS assessment note, dated 4/17/06, documented the resident's 5th toe wound remained closed and the protective treatment of the barrier film would continue.<br><br>On 5/24/06 the facility performed foot assessments on all their residents. The note by a member of the wound team documented, "Bil[ateral] feet assessed. Noted toe nails thick - resident is a diabetic. Faxed MD for request for a podiatrist. No other feet issues noted. Resident denies pain or tenderness [with] foot assessment."<br><br>The facility's Weekly Skin Integrity Assessment form documented the resident's skin was monitored on a weekly basis through 5/28/06.<br><br>The final nurses' note, dated 6/1/06, documented the resident expired after a recent decline in her physical condition.<br><br>The Director of Medicare Services was | F 314 | | |



J. Bush ED 07-17-06

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| F 314 | Continued From page 37<br>interviewed on 6/22/06 at 2:30 pm. She indicated she would look for evidence that the Podiatry consult was performed as ordered on 4/13/05. She was also asked to provide evidence that the resident's feet had been monitored on a routine basis since her admission to the facility in April 2005. At 3:00 pm the same day, the Director acknowledged the Podiatry consult had not been scheduled. Also, there were no routine foot assessments performed on this diabetic resident who had a history of calluses, corns and mycotic nails.<br><br>The DON was also interviewed earlier in the day. She acknowledged an investigation had not been initiated when the resident developed the ulcer to her 5th toe.<br><br>The facility failed to assess this diabetic resident's shoes for appropriate fit at the time of her admission to the facility and at regular intervals. The resident wore shoes which became "tight fitting" causing a pressure ulcer to one of her toes approximately ten months after her admission to the facility. | F 314 | F-324<br><br>SPECIFIC RESIDENTS<br><br>Resident # 8's is working with physical therapy services on a trial of a merry walker. The following fall prevention measures continue to be implemented:<br>• Offer activities when restless<br>• Take for short walks when restless<br>• Low bed<br>• Mat at bedside<br>• Pressure alarm in bed and wheel chair<br>• Notify family to visit when restless<br>Family and resident choose not to have 1:1 sitters at this time. They continue to be undecided as to placement in the secure unit. They have been educated related to the risk of frequent falls and wish to continue with current measures at this time. | |
| F 324 SS=D | 483.25(h)(2) ACCIDENTS<br><br>The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the facility's Incident/Accident Investigation reports, interview, and three | F 324 | | |



S. Bock ED 07-17-06

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| F 324 | Continued From page 38<br><br>complaints from the public, it was determined the facility did not ensure residents received adequate supervision to prevent accidents. This affected 2 residents (#8 & 16) of the 3 months of resident Incident/Accident reports reviewed. Resident #8 fell from her wheelchair 6 times over the course of 52 days. Resident #16, while in his wheelchair, was found outside the facility's building in the parking lot, three times in April 2006, and once in June 2006. He was found once by an off-duty employee, by an employee arriving to work, and by a staff member who happened to be looking outside a facility window. Findings include:<br><br>1. Resident #8 was admitted to the facility on 1/27/06 with diagnoses which included arthritis, dementia and Parkinson's disease. Her Admission MDS assessment, dated 2/7/06, documented the resident was moderately impaired in cognition, required one person physical assist for bed mobility, transfers, and during locomotion on her unit in the facility. Her primary mode of locomotion was the wheelchair. Her gait was unsteady. The test for balance identified, "Partial physical support during test or stands (sits) but does not follow directions for test." She had a history of falls 30 and 31-180 days prior to her admission to the facility. The RAP Summary triggered as "Fall Risk." The facility planned to proceed with care planning for falls.<br><br>Her quarterly MDS, dated 5/4/06, documented her cognition had become severely impaired and she had become a 2-person physical assist for transfers. She had fallen in the past 30 and 31-180 days. | F 324 | Resident # 16 has been transitioned to the secure unit to prevent further elopement.<br><br>OTHER RESIDENTS<br><br>This practice has the potential to affect all residents. Residents who have sustained a fall in the past 90 days care plan has been reviewed and up-dated if necessary to ensure fall prevention measures have been implemented.<br><br>SYSTEMIC CHANGES<br><br>Staff was in-serviced on fall prevention, care planning and the new accident/incident forms on7-18 and 7-19.<br><br>A new resident fall intervention tracking form has been implemented.<br><br>The accident/incidents are brought to the daily stand-up meetings for review by the IDT.<br><br>MONITORS<br>ED and DON will monitor through the daily stand-up meeting and review of each incident for completion.<br><br>DATE OF COMPLIANCE: 7-25-06 | |



S. Bolen SD 07-17-06

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 324 | Continued From page 39<br><br>Her fall risk score on 4/6/06 and 5/12/06 was "20". A score of 10 or above represented high risk, according to the facility's form.<br><br>Review of the facility's Incident/Accident Investigation reports (I/As) from April through mid June 2006, documented the following:<br><br>*4/26/06 at 9:30 am, "...Slid forward out of w/c [wheelchair] landing on knees. Has had multiple attempts to stand [without] A[ssist] [Increased agitation & aggressiveness...Was the incident witnessed? No...Type of injury: none...attempting to stand...What immediate actions were taken to provide safety for resident and/or others? Attempt to [assist] res[ident] [with] activity, also toileted, alert charting q [every] shift x 72 [hours]...Was falls alarm sounding? Yes...Approximately how long was the resident on the floor before he/she was found? Immediatley [sic]...When was the resident last seen by staff, and by whom?" This was left blank.<br><br>*4/26/06 at 6:00 pm, "... Res[ident] was found sitting on floor in another res room... [with] falls alarm going off. Multiple attempts to stand..." The report documented the fall was unwitnessed and the resident sustained no injury. The resident was "sitting in w/c trying to stand". The facility's immediate actions were, "Falls alarm in chair redirect for activities." The resident was on the floor a "few minutes" before she was found. There was no time of day listed as to when the resident was last seen by staff.<br><br>*5/11/06 at 10:00 am, "...Resident stood out of w/c stating that she needed to go to BR | F 324 | | |



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| F 324 | Continued From page 40 | F 324 | | |

[bathroom]. She lost her balance & fell [without] injury..." The fall was unwitnessed and the report did not identify the time of day the resident was last seen by staff. The immediate actions were, "Toileted, alert charting q shift x 72 [hours]." The resident was found "immediatley [sic]." The nurses' notes, dated 5/15/06, documented, "... [No] [urine] dip [test] obtained @ time of incident. Will obtain urine dip. Will attempt to establish a pattern of elimination for toileting schedule..."

*5/23/06 at 11:25 am, "...Resident stood holding hand rail lost her balance & sat on the floor..." There was no injury. The incident was witnessed by staff. There were no documented immediate actions taken by the facility to provide safety for the resident. The I/A meeting review notes documented on 5/24/06, "...Will assess for secured unit placement to provide low stim[ulation] surroundings."

*5/27/06 at 10:40 am, "...Found on floor sitting lowered self to floor..." The incident was unwitnessed. There was no injury. She was last seen by staff, "10 minutes ago." The immediate actions taken by the facility was, "Re-directed." The I/A meeting review notes documented on 5/30/06, "...Cont[inue] to work towards placement in low stim environment..."

*6/16/06 at 10:30 and 11:00 am, "...Found res on knees x 2 in LT [longterm] day room. Has been attempting to stand multiple times this shift..." The incidents were not witnessed and there were no injuries. The immediate actions taken were, "Alert charting every shift x 72 [hours]." The form did not identify when the resident was last seen by staff. The follow-up report, dated 6/19/06, documented,



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| F 324 | Continued From page 41<br><br>"Will attempt to walk her when she's restless & try a walk to dine schedule. Will try to see if she will participate in exercise program. Care plan updated."<br><br>On 6/22/06 in the morning the DON was asked to provide additional documentation that the resident received increased staff supervision when the resident continued to get out of her wheel chair and fall. The DON indicated the social service department documented their efforts to transfer the resident to the secure unit in the facility and these notes would be provided. There was no documentation of increased staff supervision available.<br><br>The social service note, dated 6/19/06, documented, "Sister [of resident] returned call does want to put res in our SCU [Secure Care Unit] does not want to give up restorative dining. Sister will not be able to be here has other obligations and wants to be able to help [with] transition. Sister is looking at the 1st part of July to complete rm [room] [change]. Explained our involvement [with] transition & she wants to be the one to tell & explain to [resident] why. Went over [increased] risks [with] her & the importance of the move knowing this still cont[inues] to want to wait."<br><br>The Director of Medicare Services was interviewed on 6/22/06 at 2:07 pm. She stated the facility started the resident on the "walk to dine" program after the 6/16/06 falls. "Activities is doing extra supervision & decreased stimulation activities." The facility did not provide any documented evidence to the investigation team. | F 324 | | |



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| F 324 | Continued From page 42<br><br>The social service staff member documented on 6/19/06 that the decision by the resident's sister to not agree to transfer the resident to the secure unit at that time, was possibly placing the resident at increased risk.<br><br>The facility failed to increase staff supervision when the resident started to make "multiple attempts to stand" and had repeated unwitnessed falls from her wheelchair. As of 6/22/06 the resident resided in the same room and without increased staff supervision.<br><br>2. Resident #16 was admitted to the facility on 12/31/01 with diagnoses which included diabetes mellitus and depression.<br><br>His most recent quarterly MDS, dated 3/22/06, identified he was moderately impaired in cognition, and required one person physical assist for transfers and locomotion. The wheelchair was his primary mode of transportation.<br><br>Review of the facility's Incident/Accident Investigation reports (I/As) from April through mid June 2006, documented the following:<br><br>*4/18/06 at 1:30 pm, "...When staff member arrived to work she found resident outside, he stated, 'I just wanted some sunshine'...Assistive device in use at the time of the incident? W/C [wheelchair]...What immediate actions were taken to provide safety for resident and/or others? Returned to facility & engaged in activity..." Under the section, ELOPEMENT, the following was documented, "Approximate duration of resident's | F 324 | | |



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| F 324 | Continued From page 43<br><br>absence: 5 min[utes] Where was the resident found? Parking lot. Who was the last person to see the resident?.." This was left blank. There was no signature/date by the Executive Director to verify the investigation was complete.<br><br>*4/18/05 at 1:50 pm, "...Resident outside in parking lot & was returned to facility... Was incident witnessed? No...Activity at the time of the incident: Attempting to elope...What resident assistive devices were in use at the time of the incident? W/C...What immediate actions were taken to provide safety for resident and/or others? Returned to room, A[ssisted] to bed, alert charting q shift x 72 [hours.]..." Under ELOPEMENT section, the following was documented: "Approximate duration of resident's absence: Approx[imately] 5 min[utes] Who was the last person to see the resident? Unknown...Describe the circumstances surrounding the elopement. Res attempting to go outside because he stated, "It looks nice out there." There was no signature/date by the Executive Director to verify the investigation was complete. This incident was less than thirty minutes after the 11:00 am incident, which documented he was, "Returned to facility & engaged in activity."<br><br>*4/27/06 at approximately 1:00 pm, "... Location of incident: Parking lot of [name of facility]...Resident was found outside by off duty employee...What resident assistive devices were in use at the time of the incident? W/C...What immediate actions were taken to provide safety for resident and/or others? Brought back to facility [sic], re fax MD re[garding[ [positive] [urine] dip [test]..." Under the section, ELOPEMENT, the following was documented, "Approximate duration of resident's | F 324 | | |



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| F 324 | Continued From page 44<br><br>absence: Unsure 5-10 minutes...Who was the last person to see the resident? Dinning [sic] room staff. Describe the circumstances surrounding the elopement: Resident was found near bridge entrance by off duty staff & return to reception area..." There was no signature/date by the Executive Director to verify the investigation was complete.<br><br>*4/28/06 at 7:00 am, "...During AM cares noted large bruise [with] large ST [skin tear] to RFA [right forearm]...Was the incident witnessed? No...Activity at the time of the incident: Unknown...Was another resident or associate involved? No. What immediate actions were taken to provide safety for resident and /or others? Alert charting q[every] shift x 72 [hours.]"...Under SKIN RELATED INJURY the following was documented: "...How did it happen? Unknown. Who was involved in alleged injury?" This was left blank. "Did the injury involve equipment? Unknown...Was there an investigation?" This was left blank.There was no signature/date by the Executive Director to verify the investigation was complete. The large bruise and large skin tear were found less than 24 hours after the resident was outside the facility and unattended.<br><br>*6/13/06 at 11:00 am, PT [physical therapist] saw resident out in parking lot & returned him [without] incident. Res stated that he was 'looking for a new set of wheels'...Was the incident witnessed?" This was left blank. "...Activity at the time of the incident: Attempting to leave facility...Returned to facility & [increased] supervision...Under the section, ELOPEMENT, the following was | F 324 | | |



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| F 324 | Continued From page 45 | F 324 | | |

documented: "Approximate duration of resident's absence: Minutes...Who was the last person to see the resident? Unknown. How was the resident found? Seen out window by staff member..."

The 6/13/06 I/A investigation report was the only report which included the form, Incident Follow-Up & Recommendation. It documented: "Summary of Investigative Facts: Resident went out to parking lot without assist, 'looking for new set of wheels', Actions taken: Brought back to facility. Follow-Up: Will dip [test] urine r/o [rule-out] UTI [urinary tract infection] & offer patio for outside area..." The Executive Director did not sign/date either form.

The nurses' notes documented the following:

6/13/06 at 10:00 pm, "[No] elopement this evening. Pleasant & cooperative [with] cares..."

6/14/06 at 10:15 am, "A/I review mtg [meeting] - on 6-13-06 at 1300 [1:00 pm] res was found outside in parking lot and showed [increased] confusion will request dip for UA[urinalysis] & offer patio for his outside needs."

The 6/13/06 I/A investigation report identified, "...Increased supervision." There was no available documentation that the facility provided the increased supervision after this or the previous incidents when the resident was found in the parking lot in his wheelchair.

On 6/21/06 at approximately 6:30 pm, the facility's regional Vice Present was advised of the surveyors' concerns about the facility's lack of



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| F 324 | Continued From page 46<br>thorough investigation of the I/As and the lack of adequate supervision to maintain residents' safety, particularly resident #16 who was found multiple times outside the facility. As of this writing, the facility has not provided any additional documentaion regarding this resident. | F 324 | | |
| F 353 SS=G | 483.30(a) NURSING SERVICES - SUFFICIENT STAFF<br><br>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.<br><br>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.<br><br>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, record review and a complaint from the public, it was determined the | F 353 | F-353<br><br>SPECIFIC RESIDENTS<br><br>Resident #'s 1, 8 and 16 are provided sufficient staff to provide nursing and related services to attain their highest practicable physical, mental, and psychosocial well-being. This includes bathing assistance, supervision to prevent falls and provision of nursing required services and assessments.<br><br>OTHER RESIDENTS<br><br>This practice has the potential to affect all residents. All residents are provided sufficient nursing staff and related services to attain their highest practicable physical, mental, and psychosocial well-being. This includes bathing assistance, supervision to prevent falls and provision of nursing required services and assessments. | |



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| F 353 | Continued From page 47<br><br>facility did not ensure sufficient staffing was provided to meet necessary care and services of residents in the following care areas: The facility failed to adequately assess, treat and monitor a resident's injury causing harm when she developed a polymicrobial infection in her toe requiring hospitalization. This deficient practice resulted in harm, constituting immediate jeopardy to the resident. The facility failed to adequately assess, monitor, and notify a resident's treating physician when her abdominal wound began to show signs and symptoms of infection and deterioration. This resulted in harm to the resident. The facility did not ensure residents received baths or showers in a timely manner and failed to provide adequate supervision and assistive devices to prevent accidents. This affected 1 of 1 sample residents (#1), 2 random residents (#8 & 16), and random residents who attend Resident Council meetings in May and June 2006. Findings:<br><br>a. Resident #1 was admitted on 3/27/06 with diagnoses including s/p (status post) exploratory laparotomy for negative appendectomy, chronic right pleural effusion, congestive heart failure, acute abdominal pain, streptococcal bacteremia, septicemia with mental status changes, diabetes mellitus, rheumatoid arthritis, atrial fibrillation, coronary artery disease, and chronic renal insufficiency. Upon admission to the facility, the resident had an open surgical wound to her abdomen.<br><br>The facility failed to adequately assess, treat and monitor a toe injury sustained by resident #1 causing harm when she developed a polymicrobial infection in her toe requiring | F 353 | SYSTEMIC CHANGES<br><br>In an effort to maintain desired staff ratios the facility has implemented the following measures:<br>• Sign on bonus<br>• Extra shift bonus<br>• Referral bonus<br>• Referral pot luck bonus<br>• Staff retention programs/activities<br>• Ongoing advertisements in surrounding newspapers<br>• On line advertisement with moving cost assistance<br>• Corporate float pool support<br>• Paying for and transporting persons to sister facility for C.N.A. classes<br>• Agency staff when necessary<br><br>The facility continues to staff at a greater than the mandated 2.4 ppd.<br><br>MONITORS<br><br>ED and DON will monitor through review of the daily staffing schedule.<br><br>DATE OF COMPLIANCE: 7-25-06 | |



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| F 353 | Continued From page 48<br><br>hospitalization and treatment with oral, topical, and intravenous antibiotics. This resulted in serious harm to the resident, constituting immediate jeopardy. On 5/23/06, a private caregiver visiting the resident, discovered a wound on the resident's right great toe and 2nd toe which required hospitalization and aggressive antibiotic treatment.<br><br>Resident #1 was harmed when the facility failed to adequately assess, monitor, and notify the treating physician in a timely manner when the resident's abdominal wound first presented with signs and symptoms of wound infection and deterioration.<br><br>Refer to F309 for specific details.<br><br>b. The facility did not ensure residents received baths or showers in a timely manner.<br><br>Resident #1's bath records were reviewed for the month of May 2006. The only documented shower was on 5/2/06. There was no other documentation in the resident's record to indicate she had been bathed or showered any time between 5/2/06 and 5/23/06 when she was transported to the emergency room for a polymicrobial toe infection.<br><br>Resident Council meeting minutes were reviewed for May and June 2006. Documentation revealed residents complained of showers being done "...hit and miss..." in both May and June. An interview was conducted with a bath aide on 6/22/06 at 10:55 am. The bath aide acknowledged that residents did not get bathed for long periods of time due to short-staffing. | F 353 | | |



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| F 353 | Continued From page 49<br><br>Refer to F312 for further details.<br><br>c. The facility failed to provide adequate supervision to prevent accidents.<br><br>Refer to F324 for further details. | F 353 | F-490<br>SPECIFIC RESIDENTS | |
| F 490 SS=G | 483.75 ADMINISTRATION<br><br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, record review, and a complaint from the public, it was determined the facility was not administered in a manner that enabled it to use its resources effectively and efficiently toward the betterment of each resident. The facility failed to adequately assess, treat and monitor a resident's injury causing harm when she developed a polymicrobial infection in her toe requiring hospitalization. This deficient practice resulted in harm, constituting immediate jeopardy to the resident. The facility failed to adequately assess, monitor, and notify a resident's treating physician when her abdominal wound began to show signs and symptoms of infection and deterioration. This resulted in harm to the resident. The facility did not ensure residents received baths or showers in a timely manner and failed to provide adequate supervision and | F 490 | Please refer to the resident specific measures identified under F-166, F-225, F-309, F-312, F-314, F-324 and F-353<br><br>OTHER RESIDENTS<br>This practice has the potential to affect all residents. Please refer to corrective measures identified under F-166, F-225, F-309, F-312, F-314, F-324 and F-353<br><br>SYSTEMIC CHANGES<br><br>Please refer to the systemic changes identified under F-166, F-225, F-309, F-312, F-314, F-324 and F-353<br><br>MONITORS<br><br>Please refer to the monitors identified under F-166, F-225, F-309, F-312, F-314, F-324 and F-353<br><br>DATE OF COMPLIANCE: 7-25-06 | |



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| F 490 | Continued From page 50<br><br>assistive devices to prevent accidents. This affected 1 of 1 sample residents (#1), 2 random residents (#8 & 16), and random residents who attend Resident Council meetings in May and June 2006. Findings include:<br><br>1. The facility failed to adequately assess, treat and monitor a resident's injury causing harm when she developed a polymicrobial infection in her toe requiring hospitalization and treatment with oral, topical, and intravenous antibiotics. This resulted in serious harm to the resident, constituting immediate jeopardy. The same resident was admitted with a surgical wound to her abdomen. The resident was harmed when the facility failed to adequately assess, monitor, and notify the treating physician in a timely manner when the resident's abdominal wound first presented with signs and symptoms of wound infection and deterioration. Refer to F 309 for detailed information regarding the immediate jeopardy and harm sustained by the resident.<br><br>2. The facility did not ensure that unwitnessed falls and/or injuries of unknown origin were thoroughly investigated to rule out abuse or neglect. Also, incident and accident reports for specific residents recorded no Executive Director or designee signatures to verify the reports were reviewed to determine if the investigations were completed. Refer to F 225 for specific details.<br><br>3. The facility did not ensure residents received adequate supervision to prevent accidents. Refer to F 324 for specific details.<br><br>4. The facility did not ensure residents received baths or showers in a timely manner. Refer to F | F 490 | | |



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| LIFE CARE CENTER OF SANDPOINT | 1125 N DIVISION ST SANDPOINT, ID 83864 |

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| F 490 | Continued From page 51<br>312 for specific details.<br><br>5. The facility did not prevent a Stage 2 pressure ulcer from developing. Refer to F 314 for specific details.<br><br>6. The facility failed to resolve resident grievances in a timely manner. Refer to F 166 for specific details.<br><br>7. The facility did not ensure sufficient staffing was provided to meet necessary care and services of residents. This resulted in harm to a resident who was not adequately assessed, monitored, and treated for a toe injury and an abdominal wound. Both wounds resulted in infection requiring antibiotic treatment. Refer to F 353 for specific details. | F 490 | | |



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| C 000 | INITIAL COMMENTS<br><br>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.<br>The following deficiencies were cited during a complaint investigation at your facility.<br><br>The surveyors conducting the investigation survey were:<br><br>Marcia Key, RN, Team Coordinator<br>Lisa Kaiser, RN | C 000 | STATE | |
| C 175 | 02.100,12,f<br><br>f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted.<br>This Rule is not met as evidenced by:<br>Refer to F 225 as it relates to the facility's failure to thoroughly investigate incidents and accidents to rule out abuse or neglect. | C 175 | C 175 Please refer to POC for F-225<br><br>RECEIVED<br>JUL 19 2006<br>FACILITY STANDARDS | |
| C 784 | 02.200,03,b<br><br>b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to:<br>This Rule is not met as evidenced by:<br>Based on staff interviews, record review, and a complaint from the public it was determined the facility failed to adequately assess, treat and | C 784 | C 784 Please refer to POC for F-309 | |



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| C 784 | Continued From page 1<br>monitor a resident's injury causing harm when she developed a polymicrobial infection in the toe requiring hospitalization and treatment with oral, topical, and intravenous antibiotics. This deficient practice resulted in serious harm, constituting immediate jeopardy to 1 of 1 sample residents (#1).<br><br>a. Resident #1 scraped her right great toe on 3/29/06 while in the facility, causing the toe to bleed at the toenail. The facility could not provide any documentation indicating the toe was assessed after the initial incident nor that it was treated or monitored. On 5/23/06, a private caregiver removed the resident's socks and observed a wound to the right great toe. The wound was visualized after the resident's toenail was pulled off due to the removal of the sock. Documentation on the incident report, dated 5/23/06, described the wound as a "...large open area..." with "yellow slough covering wound [and] necrotic tissue @ [at] tip of toe." The incident report also documented a 0.5 centimeter lesion to the medial second toe with a yellow wound base. The resident was sent to a local emergency room and admitted to the hospital for evaluation and treatment. It was determined she required intravenous antibiotics for a diagnosed infection.<br><br>This failed practice was brought to the attention of the facility's Administrator, DON, Corporate Nurse Consultant and the Director of Medicare Services on 6/21/06 at 6:15 pm. The facility was provided with specific details of this deficient practice that resulted in a serious wound to resident #1.<br><br>On 6/22/06 at 12:40 pm the facility presented the surveyors with an acceptable plan of correction and the immediate jeopardy was abated. | C 784 | | |



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| C 784 | Continued From page 2<br><br>The plan of correction was as follows:<br><br>"1. Resident #1's wound has been assessed and documented. Braden Skin Risk Assessment has been updated. Care Plan has been reviewed and updated to reflect residents current medical status.<br><br>2. All residents feet were assessed for skin breakdown on 5/23/06 and 5/24/06. No new skin breakdown was identified. Head to toe skin checks completed on residents on 6/21/06 and 6/22/06 and documented on weekly skin check sheets.<br><br>3. L.N.'s will be inserviced on LCCA's [Life Care Corporation of America's] Prevention of Pressure Sores and Other Ulcers Policy by 6/23/06.<br><br>CNA's will be inserviced on procedure for reporting skin issues on 6/23/06.<br><br>Braden Risk Assessments will be updated for all residents. Residents scoring 14 or below will have Pressure Ulcer Prevention Checklist completed. Residents identified at moderate or high risk for skin breakdown, will have Care Plan's reviewed and updated. To be completed by 6/30/06.<br><br>LN's will be inserviced on LCCA skin documentation forms for Pressure Ulcers, Stasis Ulcers, and non-pressure related skin on 6/23/06.<br><br>All skin issues identified will be recorded on approp. [appropriate] skin form, assessed weekly with documentation until resolved per LCCA policy by 6/23/06 and ongoing. | C 784 | | |



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| C 784 | Continued From page 3<br>Weekly head to toe skin integrity assessments will be performed and documented on each resident's individual Weekly Skin Integrity Assessment form by 6/22/06 and ongoing.<br><br>Residents identified with Dx. [diagnosis] of Diabetes will have weekly Diabetic Foot Checks completed by L.N. and documented on individual treatment sheets. Care Plans will be updated to reflect new intervention by 7/1/06 and on-going.<br><br>L.N. inservice on 6/23/06 to include policy & procedure for initiation and completion of Weekly Diabetic Foot Checks.<br><br>Ongoing LN inservices will be provided on Wound Assessment and Documentation, Complications of Diabetes and Prevention of Pressure Sores and Other Ulcers on New Hire Orientation, and quartly [sic] for all LN staff.<br><br>SDC [Staff Development Coordinator] will complete L.N. Competencies on Pressure Ulcer Assessment and Pressure Sore Management Treatment Modalities for each L.N. By 7/30/06. Newly hired L.N.'s will complete competencies during probationary period.<br><br>4. RCM [Resident Care Manager] will audit treatment sheets for completion of Weekly Diabetic Foot Checks, Weekly Skin Integrity Assessment forms, individual skin assessment sheets for completion daily, with copy of audit to D.O.N. by 7/1/06 and ongoing.<br><br>D.O.N. to do random audit of Weekly Skin Integrity Assessment forms, Individual Skin assessment sheets, and treatment sheets for Diabetic Foot Checks by 7/1/06 and ongoing. | C 784 | | |



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| C 784 | Continued From page 4<br>RCM will complete LCCA Weekly Pressure Ulcer Tracking form and the Weekly Non-Pressure Tracking form and forward copy to D.O.N. by 7/1/06 and ongoing.<br><br>D.O.N. will do random chart audits for residents identified with newly acquired Pressure Ulcers to ensure approp. notification, treatment plan and documentation is in compliance.<br><br>D.O.N. will do random chart audit for new admissions to ensure assessments, documentation and treatments are approp.<br><br>Audits completed and reviewed by D.O.N. will be evaluated monthly for performance improvement opportunities by the CQI [Continuous Quality Improvement] committee.<br><br>The E.D. [Executive Director] will monitor and ensure compliance."<br><br>"Amendment to P.O.C. [plan of correction] 6/22/06<br><br>The Nurse Consultant that will be in the facility/available for consultation effective 6/22/06 is [name and credentials of RN #1] (licensed in ID [Idaho]). [Name of RN #1] will be in the facility until [Name of Corporate Nurse Consultant and credentials (RN#2)] has received her ID license. [Name of Corporate Nurse Consultant] has started this process today. The Nurse Consultant will monitor and insure compliance of P.O.C.<br><br>[Name of RN #1] will remain in this capacity for a minimum of 3 wks [weeks]. At that point if [name of RN #2] has her ID license then she will become the consultant if not [RN #1] will remain until [RN #2] receives her license." | C 784 | | |



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| C 784 | Continued From page 5<br><br>b. Resident #1 was harmed when the facility failed to adequately assess, monitor, and notify the treating physician in a timely manner when the resident's abdominal wound first presented with signs and symptoms of wound infection and deterioration.<br><br>Findings include:<br><br>Resident #1 was admitted on 3/27/06 with diagnoses including s/p (status post) exploratory laparotomy for negative appendectomy, chronic right pleural effusion, congestive heart failure, acute abdominal pain, streptococcal bacteremia, septicemia with mental status changes, diabetes mellitus, rheumatoid arthritis, atrial fibrillation, coronary artery disease, and chronic renal insufficiency. Upon admission to the facility, the resident had an open surgical wound to her abdomen.<br><br>a. A nursing note, dated 3/27/06, documented the resident's admission assessment and her skin assessment was as follows: "Skin intact [with] Large Callaces [sic] noted on lateral sides of each foot...Has ST [skin tear] to LFA [left forearm] that is dry & exposed area 2 x 1.5 cm [centimeters] [with] redness noted [at] edges. Old ST to RFA [right forearm] 1.5 x 0.5 cm. CT [chest tube] insertion site to [right] lower chest wall approx[imately] 0.5 cm [with] sutures intact..." The nursing note also documented the resident had a dressing over the right lower quadrant of her abdomen.<br><br>A "Weekly Skin Integrity Assessment" form documented an assessment, dated 3/27/06. In addition to the wounds identified on the admission assessment, the form documented an | C 784 | | |



S. Bsh 2D 07-17-06

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| C 784 | Continued From page 6<br>area of "watery blisters on [left] side" and an area of skin breakdown on the resident's buttocks.<br><br>Nursing notes, dated 3/29/06 at 8:45 pm, documented "Res[ident] stated she was trying to stand at toilet [and] scrapped [sic] her [right] great toe on the slip strip causing her toe to bleed at toenail..." Nursing notes, dated 3/30/06 at 9:30 am, documented "A & I [accident and incident] Committee reviewed injury to [right] great toe which occurred 3/29/06 [at] 2000 [8 pm]. She attempted to stand by self & scraped toe on non-skid surface. Socks to be worn & reminded resident to use call lt [light]."<br><br>There was no other documentation in the nursing notes or on the weekly skin assessment forms regarding the treatment or monitoring of the toe injury.<br><br>An incident and accident report, dated 5/23/06 at 7:30 am, documented the following regarding what occurred when a visitor removed the resident's socks because they were soiled and a foul odor was noted:<br><br>"When removing socks, toe nail was pulled off [right] great toe nail revealing large open area [with] yellow slough, covering wound & necrotic tissue [at] tip of toe. Also a 0.5 cm lesion to medial 2nd toe [with] yellow bed." The report documented the wound was cleaned, a dressing was applied, and the resident was transported to a local emergency room for evaluation.<br><br>The investigation portion of the report documented a skin related injury and categorized it as an "infected lesion." The "How did it happen?" section of the investigation form documented, "Res has hx [history] of stubbing | C 784 | | |



S. Bohn SD 07-17-06

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| C 784 | Continued From page 7<br>toes on furniture during transfers."<br><br>The resident was admitted to the hospital on the same day and diagnosed with a "polymicrobial diabetic foot infection." The resident received aggressive antibiotic treatment in oral, intravenous (IV) and topical forms. The hospital discharge summary, dated 5/27/06, documented the following: "Superficial swab cultures revealed Enterococcus sensitive to vanco [Vancomycin], MRSA [Methicillin-resistant Staphylococcus aureus] sensitive to Septra and vanco and resistant to amoxicillin and sulbactam." Upon re-admission to the facility on 5/27/06, the resident was receiving IV antibiotic therapy.<br><br>A physician's progress note, dated 6/5/06, documented "I was asked to see [resident #1] today because her order for Vancomycin has expired. She was ordered for Vancomycin 1 gram Q [every] 48 hours for 14 days. Her right foot, for which the Vancomycin was ordered, looks much better. Her great toe is no longer reddened but it does have a lot of eschar on the tip and an absent nail. I see a potential space under the eschar that leads down toward the bone. I don't know if it goes all the way to the bone...I am going to continue the Vancomycin for another 2 weeks at 1 gram IV Q 48 hours."<br><br>On 6/21/06, the facility provided the surveyors with an investigation report regarding the incident that occurred on 5/23/06. The investigation was dated 6/21/06 and documented the following:<br><br>"On May 23, 2006, [visitor's name], Residents former personal caregiver at home was removing [resident #1's] socks when part of her right great toe nail came off during sock removal. [Visitor's name] then informed the team leader [name of | C 784 | | |



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| C 784 | Continued From page 8<br><br>LN], LPN what had just happened and also got Social Services Assistant [name] involved. [Social Services Assistant] then notified [a second LN's name], LPN of the incident who went to the Residents room, looked at the toe, covered it with a dressing and notified the Physician. She also notified [name of corporate nurse consultant] of the incident. An incident report was initiated.<br><br>On 5/23/06 & 5/24/06 All Residents in the facility had their feet checked for any unidentified skin issues. There was no new skin breakdown noted. MDs were notified if Podiatrist evaluations were needed. Residents that had not had a shower in the past week were identified and received a shower.<br><br>On 5/23/06, Facility investigation to rule out abuse or neglect was initiated Executive Director [name] contacted [physician's name] to find out the status of [resident #1's] great toe, he [the physician] felt at that time the infection was part of a possible Hematogenous infection that spread from her open abd [abdominal] wound, and he did not feel that this was from abuse or neglect.<br><br>On 5/24/06 [name of Executive Director] interviewed staff members who provided care to [resident #1], all staff members that were interviewed stated that they did not remember any open wounds on her right great toe & most could not remember seeing her without her socks on [,] list of staff that were interviewed [list of 10 names]...<br><br>After chart review and staff interviews abuse and neglect could not be substantiated.<br><br>Facility Management discussed plan to identify training needs of staff members and develop a | C 784 | | |



S. Bolen RD 07-17-06

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| C 784 | Continued From page 9<br>training plan/ schedule when new DON started her position on 5/31/06.<br><br>On 6/21/06 Interviewed [name of occupational therapist] who was the OT [occupational therapist] providing showers and ADL training until the end of March, during that time she was showered 3 times per week by OT. She was not making any progress so OT did not continue to work with her, [resident #1] did stub her right great toe during that time and the toe was bruised and oozing, [name of OT] did notify [name of LN] at that time and that [name of same LN] was applying a dressing."<br><br>The resident's bath records were reviewed for the month of May 2006. The only documented shower was on 5/2/06. There was no other documentation in the resident's record to indicate she had been bathed or showered any time between 5/2/06 and 5/23/06 when she was transported to the emergency room for the polymicrobial toe infection.<br><br>The bath record for the month of April revealed the occupational therapist showered the resident on 4/7, 4/10, 4/11/, 4/12, 4/17, 4/19, 4/21, 4/24, and 4/28/06.<br><br>Weekly skin assessments were documented as completed for the resident on 3/27, 4/1, 4/8, 4/15, 4/29, and 5/7/06. There was no other documentation to indicate if skin assessments had been performed after 5/7/06. The weekly skin assessments contained no documentation pertaining to the resident's feet or toes.<br><br>An interview was conducted with the DON and the RN Director of Medicare Services on 6/21/06 at 4:06 pm. When asked to provide assessments | C 784 | | |



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| C 784 | Continued From page 10<br>following the toe injury on 3/29/06, the RN Director of Medicare Services stated, "There was no injury to follow-up on..." According to the nursing notes for 3/29/06, the toe was scraped and bleeding. In regards to staff members not noticing the wound on her toe in May, she stated, "I know that she was not allowing the girls to take her socks off for a period of time." There was no documentation identifying the resident's refusals to remove her socks. The RN stated she was "shocked" when she saw the toe wound on 5/23/06.<br><br>The facility failed to adequately assess, treat and monitor this resident's injury causing harm when she developed a polymicrobial infection in the toe requiring hospitalization and treatment with oral, topical, and intravenous antibiotics. This resulted in serious harm to the resident, constituting immediate jeopardy. On 5/23/06, a private caregiver visiting the resident, discovered a wound on the resident's right great toe and 2nd toe which required hospitalization and aggressive antibiotic treatment. The facility had no documentation of ongoing foot assessments for this diabetic resident, there was no follow-up for a toe injury in late March, bath records revealed the resident received only one shower during the month of May prior to her hospitalization on 5/23/06 and the last documented skin assessment was on 5/7/06. There was no documentation in the nursing or occupational therapy notes to indicate the resident had a bruised and oozing right great toe except in the facility's investigation report dated 6/21/06.<br><br>b. At the time of admission on 3/27/06, resident #1 had an open abdominal wound as a result of an exploratory laparotomy incision that had to be re-opened during a recent hospitalization. The | C 784 | | |



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| C 784 | Continued From page 11<br>hospital discharge summary documented that when the laparotomy incision was re-opened, the wound contained clear fluid and "...did not grow any organisms on culture." The resident was discharged to the facility with orders for wound care and dressing changes.<br><br>Nursing notes regarding the wound documented the following:<br><br>*3/27/06 3:00 pm - "...Abd [abdomen] large, soft, Has drsg [dressing] over RLQ [right lower quadrant]..."<br><br>*3/27/06 9:25 pm - "...Res[ident] incision on [right] side 3 cm [centimeters] long [with] gauze packing. Dressing [changed] ABD [type of absorbent wound cover] applied. Lg [large] amt [amount] of clear drainage...Res started on 500 mg Keflex for infection..."<br><br>*3/28/06 5:00 am - "...Dressing was saturated [with] brownish sero sanguinous drainage and changed..."<br><br>*3/28/06 3:00 pm - "...Wound bed pink [with] adipose tissue exposed. Moderate amounts of serous drainage, [no] odor noted. Edges pink [without] s/sx [signs or symptoms of] inflammation..."<br><br>*3/29/06 8:45 pm - "...Dressing was [changed] on abdomen. Kerlex & NS [normal saline] applied to incision site & ABD pads covered..."<br><br>*3/30/06 2:30 pm - "...Con't [continue] [with] wound care. Area cleaned [with] NS, old dsg [dressing] had copious amounts of serious [sic] drainage [no] odor noted. Area covered [with] dry dsg..." | C 784 | | |



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| C 784 | Continued From page 12<br><br>*3/30/06 10:30 pm - "...Abdominal wound - packing in place..."<br><br>*3/31/06 3:15 pm - "...Incision to RLQ [right lower quadrant] con't to have large amounts of serious [sic] drainage [without] odor..."<br><br>*4/1/06 2:50 pm - "...Incision to the RLQ continues to have serous drainage. Dressing has been changed..."<br><br>*4/2/06 4:00 am - "...Abd[omen] wound tissue is gray marbled [with] yellow adipose tissue..."<br><br>*4/4/06 1:45 pm - "...Abd wound to RLQ con't to drain large amounts of serous drainage area open [with] adipose tissue exposed. [No] redness or s/sx inflammation [at] site..."<br><br>*4/6/06 3:00 pm - "...RLQ wound con't to have moderate to large amount of serous drainage. Old dsg has slight 'fishy' odor..."<br><br>*4/7/06 3:50 pm RLQ wound con't to have moderate to large amount of serous drainage. Wound lower edge dry & brown. Wound bed is all exposed adipose tissue. Wound con't to have 'fishy' odor..."<br><br>*4/8/06 2:50 pm - "...RLQ continues to have moderate amount of serous drainage. It also have [sic] a strong odor..."<br><br>*4/9/06 1:00 pm - "...Abd wound located on the RLQ requires wet to dry dressing which was done. The area around the wound feels a little hard to the touch, there was minimal odor today, minimal serous drainage also..." | C 784 | | |



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| C 784 | Continued From page 13<br>*4/10/06 2:30 pm - "...Abd wound has large amount of purulent drainage [with] foul odor. Lower aspect of wound black & dry...MD faxed about wound status..."<br><br>*4/11/06 2:30 pm - "...[right] abd surgical site 12.3 cm x 3.0 cm & 7.5 cm depth. Tissue gray & yellow. Copious amt odorous drainage. Tx [treatment] wet to dry increased to 3x [times] a day. Wound edges debreaded [sic] on 4/4/06. Edges are again black & tender [with] reddened surrounding area..."<br><br>*4/11/06 9:20 pm - "...Wound was filled [with] purulent pus. Black around outer edges. Has an order [sic]..."<br><br>*4/12/06 2:10 pm - "...Wound open & draining copious amounts of yellow & purulent drainage. Very foul odor coming from wound. Wound bed has exposed adipose tissue, lower aspect of wound is black & dry..."<br><br>*4/12/06 9:00 pm - "Wound was full of purulent pus...."<br><br>*4/13/06 10:10 pm - "...Dressing changed this evening [right] abdomen - purulent drainage lying in wound - soaked up by 4 x 4's and cleansed w/normal saline. Wet to dry dressing covered w/ABD. [Increased] odor."<br><br>4/14/06 4:00 am - "Dressing [change] completed [with] wound on RLQ. Purulent, foul smelling pus cleaned from bottom of wound..."<br><br>4/14/06 4:00 pm - "Late entry for 4/13/06...Abd wound con't to have copious amounts of purulent drainage & very foul odor. Outer, most inferior aspect black & necrotic..." | C 784 | | |



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| C 784 | Continued From page 14<br><br>*4/14/06 4:00 pm - "...Abd wound assessment remains unchanged from 4/13/06...Wound culture returned today faxed to MD..."<br><br>*4/14/06 9:45 pm - "Resident moved to room...for isolation precautions. Dressing change this evening- [increased] drainage on dressing - more than last evening approx[imately] 30 cc [cubic centimeters] - purulent & [increased] odor..."<br><br>*4/15/06 10:10 pm - "...[name of surgeon] was faxed concerning description of wound - return fax 'No antibiotic but to increase dressing change to 3x's daily which is being done. [name of resident's physician] faxed at 2 pm yesterday afternoon of lab results...Dressing changed this evening - continues to have purulent drainage and foul odor..."<br><br>*4/16/06 7:00 am - "...Surgical site RLQ has putrid odor, copious amts [amounts] of yellow/gray drainage. Necrotic tissue at bottom of site [with] gray wound bed. Area surrounding wound is red warm & hard to the touch..."<br><br>*4/16/06 2:55 pm - " ...Changed dressing to RLQ surgical wound. Purulent yellowish drainage noted in dressing, also after removing old dressing copious amount of the same drainage surface [sic] on the wound bed. Use sterile 4x4 to clean the excess drainage x2. Strong foul odor emitted from the wound. Dressing was changed around 1130 am, [at] 2:00 pm it was leaking through again...<br><br>*4/16/06 3:30 pm - "[name of physician] called w/new order. ATB. [antibiotic] Levaquin 250 mg [milligrams] qd [every day] x5 days [unable to read symbol] wound infection..." | C 784 | | |



S. Bdn RN 07-17-06

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| C 784 | Continued From page 15<br><br>Physician's progress notes documented the following in reference to the abdominal wound:<br><br>*4/3/06 - "...she has a fair amount discharge from the right lower quadrant wound. Today this is already been cleaned and does not look reddened or with huge amounts of exudate and she has no increased abdominal swelling..."<br><br>*4/10/06 - "...she developed some redness in her abdominal pannus...I am here today to see whether or not there is any reason to start antibiotics...The abdominal folds now look much better. They have been cleaning them aggressively. She does have a drapery of tissue but it's not looking cellulitic right now...So for now, I am not going to change any of her medications or add antibiotics..."<br><br>A physician's order, dated 4/11/06, documented, "Culture Abd wound..."<br><br>The results of the wound culture, dated 4/15/06, identified the resident's abdominal wound was infected with Proteus Mirabilis, Klebsiella Pneumonia, and Enterococcus Faecalis. The resident began oral antibiotic treatment on 4/16/06 per a physician's order.<br><br>Nursing notes from 4/16/06 through 5/2/06 document further deterioration of the wound. The surgeon examined the resident on 5/2/06 and ordered the resident to be seen by a wound specialist for placement of a wound vacuum (vac) which was done on 5/4/06.<br><br>The facility failed to adequately assess, monitor, and notify the treating physician in a timely manner when the resident's abdominal wound | C 784 | | |

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| C 784 | Continued From page 16<br>first presented with signs and symptoms of wound infection and deterioration. Nursing notes document a "fishy" smell from the wound on 4/6/06 and continued to document the presence of a foul odor with subsequent dressing changes. The resident's physician was not notified until 4/10/06 and a wound culture was not ordered until 4/11/06. Antibiotic treatment did not begin until 4/16/06, a full 10 days after the wound began to show evidence of infection and deterioration. This delay in treatment resulted in harm to the resident; her abdominal wound was infected with Proteus Mirabilis, Klebsiella Pneumonia, and Enterococcus Faecalis, required antibiotic treatment and eventually a wound vac. When the resident was admitted to the hospital on 5/23/06, hospitalization identified she had a "chronic non-healing abdominal wound." At the time of the complaint investigation on 6/21/06, the resident still required the use of a wound vac. | C 784 | | |
| C 785 | 02.200,03,b,i<br><br>i. Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including the removal or shaving of hair in accordance with patient/resident wishes or as necessitated to prevent infection;<br>This Rule is not met as evidenced by:<br>Please refer to F 312 as it addresses the facility's failure to provide grooming and cleanliness in accordance to each resident's needs. | C 785 | C 785 Please refer to POC for F-312 | |
| C 789 | 02.200,03,b,v<br><br>v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited | C 789 | C 789 Please refer to POC for F-314 | |



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| C 789 | Continued From page 17<br>to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation;<br>This Rule is not met as evidenced by:<br>Refer to F 314 as it relates to the facility's failure to prevent a Stage 2 pressure ulcer from developing. | C 789 | | |
| C 790 | 02.200,03,b,vi<br><br>vi. Protection from accident or injury;<br>This Rule is not met as evidenced by:<br>Refer to F 324 as it relates to the facility's failure to provide adequate supervision to prevent accidents. | C 790 | C 790 Please refer to POC for F-324 | |



S. Bak SD 07-17-06